ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCES
SCHOOL OF PUBLIC HEALTH

Assessment of Provider–Initiated HIV Testing and Counseling Acceptance and Disclosure of HIV Status and Factors Related to them, among Out Patient Department Patients in the DebreBirhan Referral Hospital, N. Shoa Administrative Zone, Amhara National Regional State.

By

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A Thesis Submitted to the School of Graduate Studies of Addis Ababa University in Partial Fulfillment of the Requirement for Master Degree in Public Health.

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ACRONYMs

AAU	Addis Ababa University
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
AOR	Adjusted Odds Ratio
ART	Antiretroviral Therapy
CDC	Center for Disease Control and Prevention
CI	Confidence Interval
COR	Crude Odds Ratio
DCA	District Comprehensive Assessment
DHS	Demographic Health Survey
EDHS	Ethiopian Demographic Health Survey
EPHA	Ethiopian Public Health Association
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FHI	Family Health International
GAMET	Global HIV/AIDS Monitoring and Evaluation Team
HAPCO	HIV/AIDS Prevention and Control Office
HCT	HIV Counseling and Testing
HIV	Human Immune Deficiency Virus
HIV/TB	Human Immune Deficiency Virus or Tuberculosis
IRB	Institutional Review Board
MCH	Maternal and Child Health
MTCT	Mother to Child Transmission of HIV
OPD	Out Patient Department
PITC	Provider Initiated Testing and Counseling
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
PPTCT	Prevention of Parent to Child Transmission of HIV
SPH	School of Public Health
SPSS	Statistical Package for Social Science Research
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TB	Tuberculosis
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Abstract

Background

HIV counseling and testing is the critical entry-point for engagement into treatment and care as well as for primary and secondary HIV prevention efforts. Despite the importance of this step, most HIV-infected patients globally, and particularly in resource-poor settings, are unaware of their HIV status and the uptake of Voluntary Counseling and Testing (VCT) services is relatively limited. Missed opportunities for addressing HIV testing remain unacceptably high when patients seek medical care in the period before their HIV diagnosis. HIV counseling and testing is increasingly shifting from the client-initiated towards other modalities, especially provider-initiated testing and counselling.

Objectives: The objective of this study was to asses the magnitude of PITC acceptance and disclosure and factors related to them among out patient department patents.

Methods: A facility based cross sectional quantitative survey was conducted from Dec. 1 to Jan. 10 on 414 clients attending out patient department in Debre Birhan Referral Hospital. Data were collected using structured questionnaire, entered into EPI info version 3.5.1 and analyzed by SPSS version 16. Logistic regression model was used to assess factors associated with PITC acceptance and disclosure of test result.

Result: A total of 414 subjects (response rate, 100 %) responded to the questionnaires. Acceptance of PITC among OPD patients was 83.6%. Adjusted correlates of PITC acceptance included female gender (AOR=2.27, 95% CI=1.16-4.42) and knowledge of HIV transmission (AOR=4.08, 95% CI=1.98-9.91). Individuals with protestant religion were less likely to accept PITC (AOR=0.21, 95% CI=0.06-0.72). Key barriers to accept PITC included being apparently healthy (25%), being tested before (22.1%) and fear of stigma and discrimination (19.1%).

The vast majority 120 (90.5%) of the married respondents who had ever been tested for HIV disclosed their result to at least one person. Of 346 respondents, who accepted PITC, 288 (83.2%) had a plan to disclose their result to any other person. Compared with the age group 45 and above, subjects 15-24 years old were less likely to disclose their HIV status (AOR=0.16, 95% CI=0.04-0.62). Disclosure of test result was associated with occupation (AOR=5.42, 95% CI=1.44-20.43) and test result negative (AOR=4.00, 95% CI=1.53-10.47). The reasons for non disclosure were fear of stigma 37 (62.7%) followed by fear of blame 8 (13.6%).

Conclusion and recommendation: In this study, PITC acceptance was promising and should be expanded to other health facilities. Efforts should be strengthened to decrease factors which impede HIV test result disclosure.

1. INTRODUCTION

1.1 Background

The HIV pandemic created an enormous challenge to the survival of mankind worldwide (1). The number of people living with HIV worldwide continued to grow in 2008, reaching an estimated 33.4 million. The total number of people living with the virus in 2008 was more than 20% higher than the number in 2000, and the prevalence was roughly threefold higher than the 1990 status. In 2008, an estimated 2.7 million new HIV infections occurred. It was estimated that 2 million deaths occurred due to AIDS-related illnesses worldwide in 2008. An estimated 1.9 million people were newly infected with HIV in sub-Saharan Africa in 2008, bringing to 22.4 million the number of people living with HIV (2). With a projected national adult HIV prevalence of 2.4% in 2010, Ethiopia is one of the countries most severely hit by the epidemic (1, 3) .

Data show that the number of countries that have developed national policies on HIV testing and counseling has increased in recent years. HIV counseling and testing (HCT) is as well increasingly shifting from the client-initiated model (also referred to as voluntary counseling and testing) towards other modalities, especially provider-initiated testing and counseling (4).

HCT Approaches

1.1.1 Client-initiated voluntary counseling and testing (VCT)

Voluntary counseling and testing is initiated by clients seeking to know their HIV status (5). Studies among adults in developing countries report that VCT is efficacious in promoting behavior change (6, 7).

1.1.2 Provider-initiated testing and counseling (PITC)

This refers to HIV testing and counseling recommended during treatment by health care providers to enable specific clinical decisions to be made and/or specific medical services to be offered that would not be possible without knowledge of the person's HIV status (5). The policies also encourage health care

providers to propose testing and counseling to everyone, regardless of presenting symptoms and type of facility (4).

1.1.3 Mandatory and compulsory HIV testing

Compulsory HIV testing can only be performed for specific reasons with individuals or groups when requested by court. Mandatory screening of donated blood/organ/tissue is also recommended (5).

1.2 Rationale of the study

To benefit from available care and treatment options, patients should first be counseled and tested for HIV. HIV counseling and testing (HCT) is a key strategic entry point to prevention, treatment, care and support services. This is critically important for individuals and couples to learn about their HIV status and make informed decisions about their future (5).

The current rapid development in HIV counseling and testing has necessitated reviewing and updating the guidelines for HCT, especially in the area of policy and implementation. Improved availability of antiretroviral medications and better treatment of opportunistic infections have created the opportunity to expand PITC in health facilities thereby increasing access (5, 7).

Although diverse client-initiated and provider-initiated models are increasing service availability and more people are being tested for HIV, people's knowledge of HIV status remains low and HIV infection is often diagnosed late. Low uptake of HIV testing is one of the reasons for delayed access to antiretroviral therapy for people in need of and in high mortality in the months after treatment is initiated (4, 8).

According to WHO/UNIDS Guidance on PITC, countries are categorized according to the HIV epidemic types: When the recorded infection is largely confined to individuals with higher risk behavior it is low-level HIV epidemics, if HIV has spread rapidly in a defined sub-population, but not in the general population it is designated as concentrated epidemics and if HIV is firmly established in the general population it is labeled as generalized epidemics (9).

In all types of HIV epidemics, health care providers should recommend HIV testing and counseling as part of the standard care to all patients who present to health facilities with signs, symptoms or medical conditions that could indicate HIV infection (9). In generalized epidemics where an enabling environment is in place and adequate resources are available, health care providers should recommend HIV testing and counseling to all adults and adolescents seen in all health facilities regardless of whether the patient shows signs and symptoms of underlying HIV infection (9).

Ethiopia is grouped among the generalized epidemic countries, where HIV testing is recommended for all out patient department patients (9). There are researches done on PITC acceptance and willingness with possible sign and symptoms including tuberculosis (4, 10-12). But WHO recommends provision of HIV test irrespective of the clinical signs for generalized epidemic countries, including Ethiopia (9).

DebreBirhan Referral Hospital has implemented the routine HIV testing for all out patient department patients, therefore, the aim of this study was to assess uptake of PITC among out patient department (OPD) clients. After determining the prevalence of HIV among OPD clients, assessing PITC acceptability and disclosure of test result, the study would be used for future scale up of the strategy at all levels (9).

2. LITERATURE REVIEW

2.1. Overview of HIV/AIDS

There are around 33.4 million people living with the virus globally (2). In the year 2008, there were about 31.3 million adults living with HIV/AIDS. Moreover, 15.7 million women and 2.1 million children were living with the virus. In 2008, there were 2.7 million new infections, and from those about 2.3 million were adults and 0.43 million were children under 15 years (2). Sub-Saharan Africa remains the region most heavily affected by HIV worldwide, accounting for over two thirds (67%) of all people living with HIV and for nearly three quarters (72%) of AIDS-related deaths in 2008 (2, 13). In sub-Saharan Africa there were 22.4 million adults and children living with the virus in the year 2008, with an adult prevalence of 5.2% (2).

According to the adjusted single point HIV prevalence estimate published by the Federal HIV/AIDS Prevention and Control Office (FHAPCO), about 2.4% of Ethiopia's adult population were living with HIV in 2010 (3, 14). The 2005 EDHS data indicated an adult HIV prevalence of 1.4% and the HIV prevalence in women was 1.9%, while that for men was 0.9% (15, 16).

HIV infection levels increase directly with educational status among both women and men and are markedly higher among those who have a secondary or higher education compared with those with less education (15). Employment is also related to HIV levels among both women and men, with those who are employed being more likely than the unemployed to be infected. Both women and men in the highest quintile of the wealth index have substantially higher rates of HIV infection than those in other wealth quintiles (15).

2.2. HV Counseling and Testing (HCT)

HCT is not an end point, but rather an entry point to the prevention-to-care continuum (13). The availability and uptake of HCT services continued to increase in 2008. Many countries have taken steps to increase utilization of HIV testing services (2). The expansion of HCT services was accompanied by an increase in uptake of the services (4). In population-based surveys conducted between 2005 and 2008, the median percentage of respondents aged 15–49 years living with HIV who reported having ever

received a test and test results prior to the survey increased from about 15% (2005–2006, 12 countries) to 39% (2007–2008, 7 countries) (4). The use of diverse and appropriate provider-initiated and client-initiated approaches is necessary to expand HIV testing and counselling uptake and facilitate access to prevention, care and treatment services (4). In 66 low- and middle-income countries with comparable data, the total number of health facilities providing HCT increased by about 35%: from 25 000 in 2007 to 33 600 in 2008 (4).

A total of 1,823 public and private health facilities were providing HCT services in December 2009 in Ethiopia (14). The number of clients using HCT services has significantly increased to 5.85 million people (53% male) in 2008/09 which is a 22% increase from the previous year (14). No single approach or service delivery model is suitable for all populations, or feasible in all settings. Choices and approaches will depend on the needs, availability of resources and accessibility (5). These results can be attributed to the expansion of provider-initiated HIV testing and counseling in health care settings along with diverse client-initiated and community-based approaches. Yet, despite the expansion of services, knowledge of HIV status remains low (5).

2005 EDHS showed that coverage rates for HIV testing among eligible respondents (all women age 15-49 and all men age 15-59), was 83 % of the women and 76 % of the men (15). For both sexes combined, coverage was 80 %. Rural residents were more likely to be tested than their urban counterparts, 85 % and 67%, respectively. The coverage rates for testing in the EDHS tend to rise with age and those with little or no education were more likely to have been tested, while men and women with at least some secondary education were least likely to be tested. On the other hand, those in the highest quintile of the wealth index were the least likely to be tested (15). On the other hand, a case-control study done on the predictors of HIV testing among patients with tuberculosis in North West Ethiopia showed that individuals who had formal education and government employees were more likely to have been tested for HIV (17).

The 2005 EDHS results showed that among the adult population aged 15-49, only four percent of women and six percent of men reported that they had been tested for HIV at some time (15). Bearing in mind the sample difference between the 2008 survey and the 2005 DHS, the proportion of women ever tested for

HIV had increased from 4% (DHS 2005) to 28% (2008 DCA) (14). Young men were about three times as likely as young women to have been tested for HIV (six percent and two percent, respectively) (15). Considering marital status, testing rates were highest among never-married women and men who have ever had sex and widowed, divorced and separated men (15).

2.3 Willingness and Acceptability of PITC and its Barriers

From the study of acceptability of routine HIV counselling and testing, and HIV sero prevalence in Ugandan hospitals, 98% of them accepted HIV testing (18). The prevalence of HIV was 28% in patients who had never been tested before and 9% in those who had previously tested negative (18).

Another study on the acceptability of HIV counselling and testing among tuberculosis patients in south Ethiopia showed that the overall acceptability rate was 35% (56/161) (19). Fourteen (20.6%) were HIV positive and women were more likely to be HIV infected ($p = 0.029$) (19). A study on missed opportunity for PITC in rural Haiti also shows that, PITC was associated with high uptake of HIV testing and reduce delay of HIV infection diagnosis and the HIV prevalence were 3.1% (20). A study on initial outcomes of an emergency department rapid HIV testing program in Western Kenya also showed out of patients who were approached for HIV testing, 97.7% patients were tested for HIV and 22.7% of the patients tested were HIV positive (21).

In the study of uptake of provider initiated HIV counseling and testing (PICT) among OPD clients with possible clinical sign of HIV infection in Addis Ababa, pre test acceptability of PITC was 68% (12). Among the 263 clients who tested for HIV, 99 of them were positive, which makes the HIV prevalence 37.6% (12). Knowledge variables such as HIV cure, know any one who is infected with HIV /who has died of AIDS and knowledge about means of HIV transmission/prevention were not significantly associated with PITC acceptability at ($p<0.05$) (12). Having the knowledge about PITC and feeling that PITC had an influence were not significantly associated with PITC acceptability at ($p< 0.05$) (12). Age group 25-34 years was found to be significantly associated with PITC acceptability (AOR=6.4; 95% CI=1.2-33.6) compared to age group 15-24 years (12).

From the study of uptake of provider initiated HIV counseling and testing (PICT) among OPD clients with possible clinical sign of HIV infection in Addis Ababa, most 164 (92.7%) of participants felt that PITC is important to start ART timely (12). On the other hand, 19 (10.8%) thought that PITC has an influence on clients to go to the health facility for fear of HIV test (12, 22).

From the experience of provider initiated HIV testing done on the uptake of HIV testing and willingness for provider initiated HIV counseling and testing among tuberculosis patients in Addis Ababa, 86% of patients were willing for PICT. Being older age and having demand for HIV test correlates with willingness for PITC (11, 12). The potential barriers for HIV testing according to the study were self trust (41.1%), lack of risk perception for HIV (24.4%), fear of learning positive result (3.9%) and stigma (11, 12).

Another cross-sectional, population-based study in Botswana showed that routine HIV testing policy would decrease barriers to testing (89%), HIV-related stigma (60%), and violence toward women (55%), and would increase access to antiretroviral treatment (93%) (22). Most participants (81%) reported being extremely or very much in favor of routine testing, while 43% of participants believed that routine testing would lead people to avoid going to the doctor for fear of testing, and 14% believed that this policy could increase gender-based violence related to testing (22) .

Experiences with voluntary and routine testing showed that, 68% felt that they could accept HIV test (22). Key barriers to testing included, fear of learning one's status (49%), lack of perceived HIV risk (43%), and fear of having to change sexual practices with a positive HIV test (33%) (22). A study done on assessing missed opportunities for HIV testing in medical Settings in the United States also showed that barrier to testing may relate to time pressures and absence of a structured system to facilitate testing (8). A study conducted in a South African State Hospital members of the medical staff indicated that 26% of the participants (15/58) had incomplete basic HIV/AIDS knowledge (23).

A case control study in North West Ethiopia also showed that knowledge on HIV/TB, ever heard of provider initiated HIV counseling and testing, perceived risk of HIV infection, awareness of the benefits of HIV testing, and perceived stigma were strongly associated with uptake of HIV testing (17). In

multivariate analysis, individuals who had formal education were 2.35 times more likely to be tested for HIV than illiterates, [OR=2.35, (95% CI: 1.33, 4.13)]. Individuals with a high awareness about the benefits of HIV counseling and testing were more likely to be tested than individuals with low awareness, [OR=3.14, (95% CI: 1.77, 5.50)] (17). On the other hand, willingness for PITC is not significantly associated at ($P<0.05$) with sex, religion, ethnicity, marital status and occupation (12).

Qualitative findings also revealed that low awareness of HIV, stigma and discrimination of people who live with HIV, low perceived risk and partners trust were the major reasons for non-acceptance of HIV testing (17).

2.4 Willingness to disclose test result and its factors

Researches done in Zambia and Kenya on ANC receiving mothers showed that the rate of partner disclosure of HIV status amongst study participants ranged from 58 % to 72 % (24). The disclosure varied with HIV status, with HIV-positive women being less likely to have intention to disclose than HIV-negative women (24-26). There were no statistically significant differences in the outcomes of disclosure between HIV positive and HIV negative women within each site (24). A study done on missed opportunities for earlier HIV testing and diagnosis at the health facilities of Dessie Town, North East Ethiopia showed that, of HIV positive clients, 40.0% (6/15) were not willing to disclose their results to their partners (27). Moreover, half of the clients, 50.0% (3/6), who were not willing to tell to their partners also refused to disclose their results to other persons (27).

A study done on disclosure experience and associated factors among HIV positive men and women in South West Ethiopia showed that of the study participants who were taking ART 71.6% (505), majority 94.5% (666) disclosed their results to at least one person and 90.8% (640) disclosed to their current main partner. Among those who did not disclose, 54% (380) stated their reason as fear of negative reaction from their partners. Respondents reported disclosing most frequently to main partners 90.8% (640) followed by relatives 33.2% (234), mother 14.9% (105), friends 14.2% (100), father 9.1% (64), neighbors 6.8% (48), children 6% (42), other family members 4.7% (33) and religious leaders 4.4% (31) (25, 28). Reasons for non-disclosure among those respondents who did not disclose their test results to their partners (n =65) were "my partner might get angry with me" (20.4%), "fear of separation/divorce"

(17.3%), "my partner might be afraid of catching HIV from me" (16.3%), "not to worry partner"(9.2%), "fear of being labeled a bad person" (6.1%), "no enough time to discuss because my partner works in other areas (28). This was also supported by the studies done in ANC attendant mothers in Africa and Ireland (24, 29).

In the study of factors affecting acceptance of HIV testing among antenatal care attendees in Wolaita Zone, fear of divorce, blame, rejection and violence, which accounted for 77 (36.4%), 70 (33.1%), 45 (21.3%) and 19 (9.2%), respectively were reasons of pregnant women not to disclose their positive test result (26). Study done in Tanzania showed that fear of being stigmatized and discriminated were the key reasons for not disclosing their results (25). At the same time, half of the respondents (50.7%) expressed that it was difficult to disclose their current test result to male partners, but the rest half had replied that it was easy to disclose (26).

Individuals who live in the same house with their partners were 9.2 times more likely to disclose to their partner compared to those who do not live in the same house (28). Respondents that reported not knowing their partner's HIV status were 98% less likely to disclose to a partner in comparison with those who did know their partner's status (28). Another study has found out that female gender increases the risk of poor interaction with ones family after HIV diagnosis and male HIV positive clients were found to be less rejected by others after their HIV diagnosis (11).

2.5. Conceptual framework

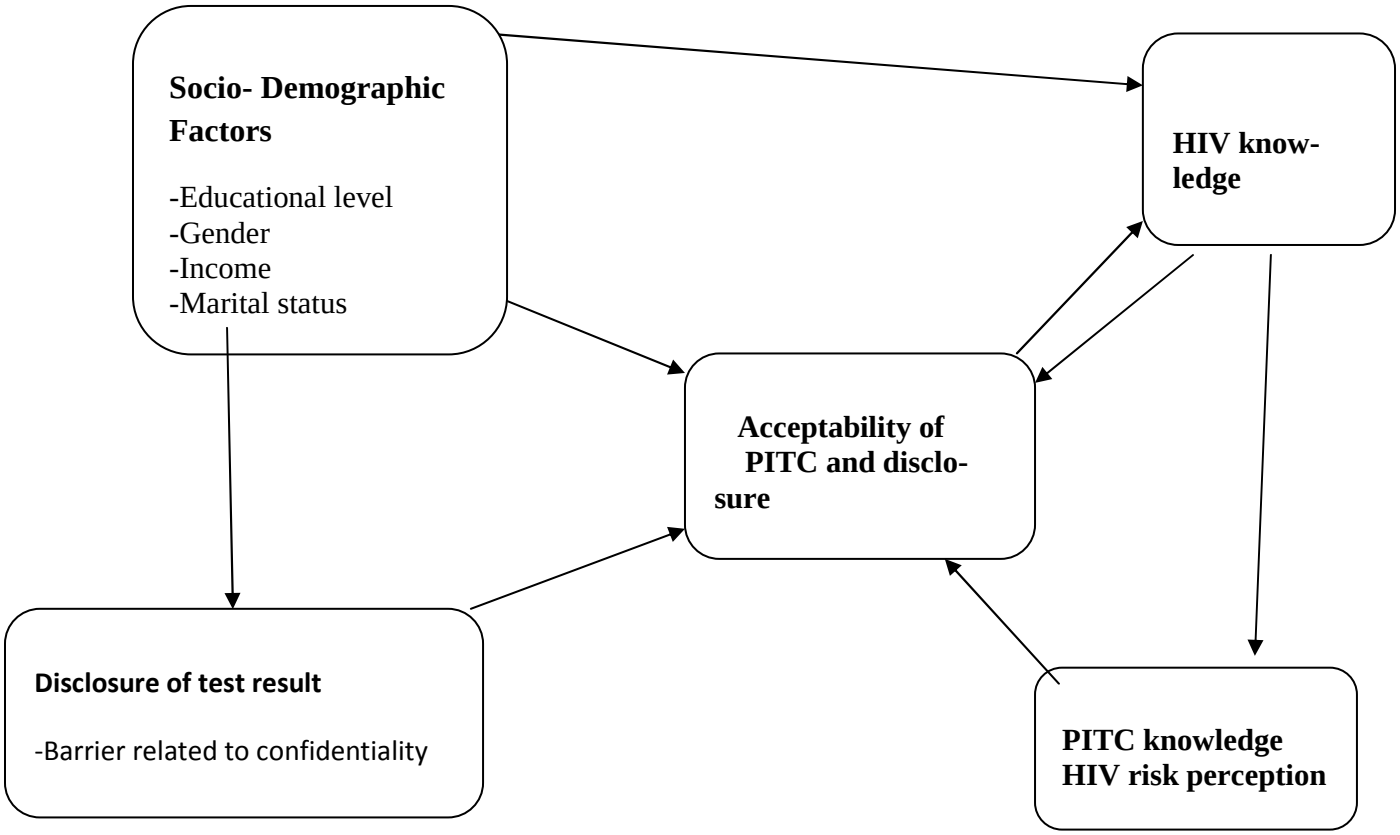

Fig.1 Hypothesized Model for Predictors of Testing and test result disclosure

The different literature reviewed showed that HIV risk perception, knowledge about HIV and knowledge about PITC were the main predictors for testing. More over, some socio demographic characteristics, attitude towards disclosure and perceived barriers for HIV test and disclosure were also important in predicting the acceptance of the PITC and test result disclosure (22).

Based on this, the study used the aforementioned four variables as a predictor for the acceptance of the PITC and test result disclosure.

3. OBJECTIVES

3.1 GENERAL OBJECTIVES

- To determine the magnitude of PITC acceptance and disclosure and factors related to them among OPD clients at Debre Birhan Referral Hospital.

3.2 SPECIFIC OBJECTIVES

- To determine the magnitude of the PITC acceptance
- To asses the attitude of out patient department patients towards disclosure of their HIV status and
- To determine factors affecting PITC acceptance
- To determine factors affecting disclosure of HIV test result among OPD patents at Debre Birhan Hospital.

4. METHODOLOGY

4.1 Study area

The study was carried out from Dec. 1 to Jan. 10 in Debre Birhan Referral Hospital which is located in North Showa Administrative Zone, 695Km from the Capital City of the Amhara National Regional State and 130 Km from the Capital of Ethiopia, Addis Ababa. Administratively, the Town has 9 urban kebeles with a total population of 67,243, of whom 34,055 are men and 33,185 are women in 2005 (15).

The District has one referral hospital, one health center, two up graded health centers and five private clinics. HCT is provided in all governmental health institutions and in one private higher clinic in the Town.

The Referral Hospital has out patient, Inpatient, Delivery and Emergency departments. There are 120 clinical staff and 114 administrative staffs in the hospital. HCT is one of the programs that the Referral Hospital is providing. PITC is one of the approaches of HCT. This study focused only on the Referral Hospital because it provides PITC for all out patients, but the health center provides only for patients with sign and symptoms of HIV.

4.2 Study Design

A facility based cross sectional quantitative survey was conducted among OPD clients to assess uptake of PITC and disclosure of HIV status and factors affecting them in Debre Birhan Referral Hospital. The study also included an internal comparison of two groups. Those groups were (PITC acceptors versus non–acceptors, among PITC acceptors, those who have a plan to disclose their test result versus not intending to disclose their test results).

4.3 Source population

The source populations of the study were all OPD clients of DebreBirhan Hospital who were 15 years and above.

4.4 Study population

The study populations were all OPD clients of age ≥15 years attending DebreBirhan Hospital during the study period.

Inclusion criteria

Any OPD clients who were ≥15 years of age and given provider initiated counseling for HIV testing during the time of data collection.

Exclusion criteria

Out patient attendants who were positive for HIV and on ART.
Out patient attendants who were comatose or psychotic patients.

4.5 Sample size

The sample size was determined using the following assumptions (level of confidence of 95%; Z α/2= 1.96). A 5% margin of error (d= 0.05) and a proportion of 43% PITC acceptance from a previous study in health facilities of Dessie Town (27). Based on this assumption, the actual sample size for the study was computed using the formula for single population proportion as indicated below.

$$n = \frac{(Z\ \alpha/2)^2 P\ (1- P)}{d^2}$$

Where:

n = the desired sample size

P = the proportion of OPD clients who were willing/accept the HIV test and it was 43% (27).

Z α/2 = Critical value at 95% confidence level of certainty (1.96)

d = the margin of error between the sample and the population = 5%

Taking the proportion of PITC acceptance from all OPD patients (27) the sample size was 376 to which a non-response rate of 10% was added. Then, the total sample size required for the study was 414 OPD clients who were provided with PITC for HIV infection.

4.6 Sampling technique

All OPD clients who fulfilled the inclusion criteria were included in the study using every other client fashion. There were four adult OPDs in the hospital. Each OPD treated medical, surgical and gynecology cases. A structured questionnaire, consisting of both closed and open-ended questions, was used to collect data. The questionnaire was adopted from similar studies (10, 12, 15, 28).

4.7 Data collection procedures

A pre-tested, structured interview administered questionnaire was used to collect the data. Five data collectors, who have taken PITC training and can speak Amharic Language, were recruited. The data collectors were general practitioners and health officers by professions. One supervisor was selected from the Debre Birhan Referral Hospital. The enumerators and the supervisor were given training for two days on aim of the study, procedures, techniques and ways of collecting data. The questionnaire was initially prepared in English and then translated in to Amharic. The Amharic version was again translated back to English by another translator to check for any inconsistencies or distortions in the meaning of words & concepts. Information on variables such as score of demographic characteristics, PITC acceptance and disclosure was collected. The principal investigator and supervisor frequently supervised the data collection process by checking completeness of the required type of data to correct faults if any on the spot. The data collection forms (questionnaires) were checked for completeness and consistency before data entry by the principal investigator. Fully (appropriately) completed questionnaires were coded. The investigator with the data clerk entered coded questionnaires into EPI info version 3.5.1 statistical package. All of the questionnaires were double entered to verify the accuracy of data entry. After data entry was done, data clean up was performed by running frequencies of each variable to check for accuracy, outliers, and consistencies.

4.8 Data quality Assurance

To assure the quality of the data, properly designed data collection instrument and training of both data collectors and supervisor was done. The collected data was reviewed and checked for completeness and relevance by the supervisor and principal investigator each day. Data was entered with EPI info. The data collectors were experienced professionals.

4.9 Data Analysis

The collected data was entered in to EPI info version 3.5.1 for cleaning and was exported to SPSS version 16 for statistical analysis. To asses the associations between independent variables and dependent variables two strategies were used and those included:-

1. Independent variables were fit in to a separate binary logistic regression model
2. All variables which were analyzed using bivariate logistic regression were fitted in to a multivariate logistic regression model to control the effect of confounders and to come up with independent predictors of PITC acceptance and disclosure of test result.

Odds ratio was used to examine group differences and to ascertain the influence of residence, age, sex, education, employment status, religion, marital status, and ethnic group. Cognitive variables (individual's knowledge about HIV/AIDS and PITC) and sexual behaviors were considered on the proportion of PITC acceptance and disclosure. CI was used to see the strength of association. P values of less than 0.05 and a confidence level of 95% by a two-sided test were considered to indicate statistical significance. To describe the characteristics of the study population, means, SD, medians, and proportion were calculated.

4.10 Study variables

Dependent variables:-

- PITC acceptance
- Attitude to HIV result Disclosure

Independent Variables included:- (Explanatory variables)

Age, sex, education, employment status, religion, marital status, ethnic group
Cognitive variables (individual's knowledge about HIV/AIDS and PITC), Sexual behaviors
Perceived barriers for HIV test and disclosure (stigma and disclosure, fear of rejection, divorce and blame).

Measurement of variables

1. **Knowledge on HIV transmission**

To come up with a comprehensive knowledge of the study participants on HIV transmission, the correct response for each of the five knowledge questions on ways of HIV transmission was given a score of one, while a zero score was given to every wrong response. The score was summed and mean was computed. Study participants who scored above the mean score were considered as knowledgeable, while those who scored less than or equal to the mean score were considered as not knowledgeable on HIV transmission. In the case of HIV transmission misconception, respondents were considered as having HIV transmission misconception if there was any mistake on the four questions and no misconception if the respondents answered all the four questions correctly.

2. **Knowledge on HIV prevention**

Regarding the knowledge of the respondents about HIV prevention, the correct response for each of the three knowledge questions on HIV prevention methods was given a score of one, while a zero score was given to every wrong response. The score was summed and mean was computed. Study participants who responded above the mean score were considered as knowledgeable, while those who responded less than or equal to the mean score were considered as not knowledgeable on HIV prevention methods.

4.11 Ethical consideration

The proposal was submitted to the Institutional Review Board (IRB) of the Addis Ababa University, Faculty of Medicine for approval. Following the endorsement by IRB, Debre Birhan Referral Hospital was informed about the objective of the study through a support letter from the School of Public Health, AAU and written permission was obtained from the Hospital Administration. As the study was conducted through interview of OPD patients, the individual patients were informed about the aim of the study and confidentiality of the data. Informed consent was obtained from study subjects who were given PITC. To preserve the confidentiality, nurses and physicians working in OPD of the DebreBirhan Referral Hospital interviewed patients who fulfilled the inclusion criteria. Moreover, no personal identifiers were used on the data collection form. The collected data was never accessed by a third person, except the principal investigator, and was kept with a firm confidentiality in a much secured place.

4.12 Communication of the results

Findings of the envisaged study shall be disseminated or communicated to Debre Birhan Referral Hospital where the study was conducted, the Regional Health Bureau, to the School of Public Health and FMOH through hard copy and presentation. The findings will also finally be published to access others.

Operational definition

- **Provider-Initiated HIV testing and counseling-** is a process in which the individual undergoes HIV testing and counseling initiated by health providers.
- **Acceptability -**The proportion of OPD attending patients showing readiness for HIV testing after pre test information and actually tested.
- **Non-acceptors-** OPD clients who refused PITC.
- **Disclosure-**Telling test result for sexual partner or any other person.
- **Risk perception for HIV/AIDS:** respondents feeling of vulnerability of being infected with HIV/AIDS.
- **Knowledgeable about HIV transmission:** Study participants were considered as knowledgeable if the mean score of the response on HIV transmission questions is above the mean, while they were considered as not knowledgeable, if the mean score was less than or equal to the mean score of the response (Annex III).
- **Misconception**: Study participants were considered to have misconceptions about HIV/AIDS transmission and prevention, if they responded factors that do not enhance HIV transmission as transmitter of the virus (Annex III).
- **Knowledge about HIV prevention:** respondents were considered to be knowledgeable about HIV prevention, if the mean score of the response on HIV prevention questions was above the mean while they were considered as not knowledgeable, if the mean score was less than or equal to the mean score of the response (Annex III).

5. RESULTs

5.1 Socio demographic characteristics of the respondents

A total number of 414 respondents who fulfilled the inclusion criteria (100% response rate) were included in the study. The age of the respondents ranged between 15 and 82 years, with the median age and inter-quartile ranges of 25 and 19 years respectively. Regarding the age distribution of the participants, the majority 181 (43.7%) were with in the age range of 15-24, followed by 108 (26.1%) between 25-34 age range. Two hundred fifty five (54.3%) of the participants were male (Table1).

Most of the respondents 355 (85.7%) were Orthodox Christians by religion, followed by Muslim 39 (9.4%). The ethnic distribution of the participants constituted Amhara 368 (88.9%), Oromo 19 (4.6%) and Gurage 11 (2.7%). Regarding the marital status of the participants, 194 (46.9%) were married, 177 (42.8%) were single and 21 (5.1%) divorced (Table1).

As far as their educational status is concerned, 69 (16.7%) were illiterates and 12.6%, 34.5%, 18.1%, and 18.1% were at the level of tertiary, secondary, primary and literate (can read and write), respectively. Regarding the occupational status, 149 (36%) of the participants were students followed by house wife 64 (15.5%), Governmental employees 58 (14%) and merchant 53 (12.8%). Out of the total interviewed clients, 45.5% could respond on the amount of their income. From those who responded on their income 20.3% earned monthly income of 500-1000 birr (Table 1).

Table 1: Socio demographic characteristics of OPD clients who were provided PITC in DebreBirhan Referral Hospital, 2010 (n=414)

Variable		Number	Percentage
Age group	15-24	181	43.7
	25-34	108	26.1
	35-44	55	13.3
	>=45	70	16.9
Sex	Male	225	54.3
	Female	189	45.7
Religion	Orthodox	355	85.7
	Muslim	39	9.4
	Protestant	20	4.8
Ethnicity	Amhara	368	88.9
	Oromo	19	4.6
	Gurage	11	2.7
	Tigray	8	1.9
	Other	8	1.9
Marital status	Married	194	46.9
	Single	177	42.8
	Divorced	21	5.1
	Widowed	15	3.6
	Living together	7	1.7
Education	Illiterate	69	16.7
	Read and write	75	18.1
	Primary	75	18.1
	Secondary	143	34.5
	Tertiary	52	12.6
Occupation	Merchant	53	12.8
	House wife	64	15.5
	Student	149	36.0
	Government	58	14.0
	NGO employee	20	4.8
	Un employed	28	6.8
	Daily laborer	9	2.2
	Farmer	24	5.8
	Other	9	2.2
Income	<500 birr	42	10.2
	501-999	84	20.3
	>1000	62	15.0
	No income	78	18.8
	No response	148	35.7

5.2 Knowledge and risk perception about HIV/AIDS

Almost all 413 (99.8%) of the participants have heard of HIV or the disease called AIDS. Three hundred sixty five (88.2%) of the participants knew that there is no cure for HIV/AIDS. Most of the respondents 399 (96.4%) mentioned sexual intercourse as a means of HIV transmission. One hundred seventy nine (43.2%), 148 (35.7%), 156 (37.7%) and 244 (58.9%) mentioned mother to child during pregnancy, mother to child during breastfeeding , blood contact and sharing sharp material as a means of HIV transmission respectively. In general 109 (26.3%) of the participants were knowledgeable about HIV transmission methods (Table 2).

Almost all of the participants were aware of that HIV is not transmitted by eating together 414 (100%), shaking hands 410 (99%), sharing cloths 414 (100%) and mosquito bite 414 (100%). Generally almost all of the respondents are knowledgeable on ways through which HIV is not transmitted (99%). Regarding means of HIV prevention, 358 (86.5%) mentioned abstinence followed by 234 (56.5%) being faithful and 181 (43.7%) using condom. One hundred eleven (26.8%) were knowledgeable about HIV prevention methods. Two hundred eighty six (69.1%) and 371 (89.6%) of participants know anyone who is infected with HIV and /or who has died of AIDS and believed that a healthy looking person be positive for HIV respectively. Only one hundred fifty five (37.4%) of the participants perceived themselves as having risk for HIV. Risk rating for the participants was, 112 (27.1%) as low followed by 31 (7.5%) as medium (Table 2).

Table 2: Knowledge of HIV/AIDS and risk perception among OPD clients who have been provided with PITC in DebreBirhan Referral Hospital, 2010 (n=414)

Variables	Number	Percentage
Can HIV be cured?		
Yes	33	8.0
No	365	88.2
I don't know	16	3.8
Means of HIV transmission		
Sexual intercourse	399	96.4
Mother to Child during pregnancy	179	43.2
Mother to Child during BF	148	35.7
Transfusion of infected blood	156	37.7
Sharing of Sharps with someone who is infected (Needles, etc)	244	58.9
Shaking hands a person living with HIV/AIDS	410	99.0
Wearing clothes of a person living with HIV/AIDS	414	100.0
Sharing a meal with a person living with HIV/AIDS	414	100.0
Mosquito bite Blood contact	414	100.0
Means of HIV prevention		
Avoiding Sex (abstinence)	358	86.5
Using a condom every time during sex	181	43.7
Staying with only one uninfected partner faithful	234	56.5
One knows any one who is infected with HIV/ who has died of AIDS		
Yes	286	69.1
No	128	30.9
Healthy looking person can be Positive for HIV		
Yes	371	89.6
No	43	10.4
Do you think you can get the virus?		
Yes	155	37.4
No	259	62.6
Chances of getting infected with HIV (n=155)		
High	12	2.9
Medium	31	7.5
Low	112	27.1

5.3 Provider-initiated HIV testing and counseling

Out of the total interviewed OPD patients, 353 (85.3%) knew about PITC and their main source of information were health workers 252 (71.4%), followed by mass media 84 (23.8%) (Table 3).

Table 3: PITC (knowledge, acceptability) among OPD Clients in DebreBirhan Referral Hospital, 2010(n=414)

Variables	Number	Percentage
Have you ever heard of PITC (n=414)		
Yes	353	85.3
No	61	14.7
Source of information for PITC (n=353)		
Health workers	252	71.4
Mass media	84	23.8
Family member	2	0.6
Friends	15	4.2
Do you feel that PITC is important?(n=353)		
Yes	345	83.3
No	6	1.4
To what extent do you support PITC (n=345)		
Very much in favor	204	57.8
Much	126	35.7
Some what	19	5.4
Not at all	4	1.1
Do you feel that PITC has influence on follow up? (n=353)		
Yes	50	12.1
No	298	72.0
Should any one check for HIV sero status? (n=414)		
Yes	393	94.9
No	21	5.1
At which time should one be tested for HIV?(n=414)		
When one is sick	94	22.7
Before marriage	147	35.5
If one has MSP	48	11.6
At any time	314	75.8
Have you ever been tested for HIV?(n=414)		
Yes	229	55.3
No	185	44.7
What was the reason of having HIV test?(n=229)		
Self interest	172	41.5
Initiated by health worker	50	12.1
During ANC	5	1.2
For blood donation	2	0.5
unless you decline we will conduct test for you (n=414)		
Yes	346	83.6
No	68	16.4
Test result (n=346)		
Positive	33	9.5
Negative	313	90.5

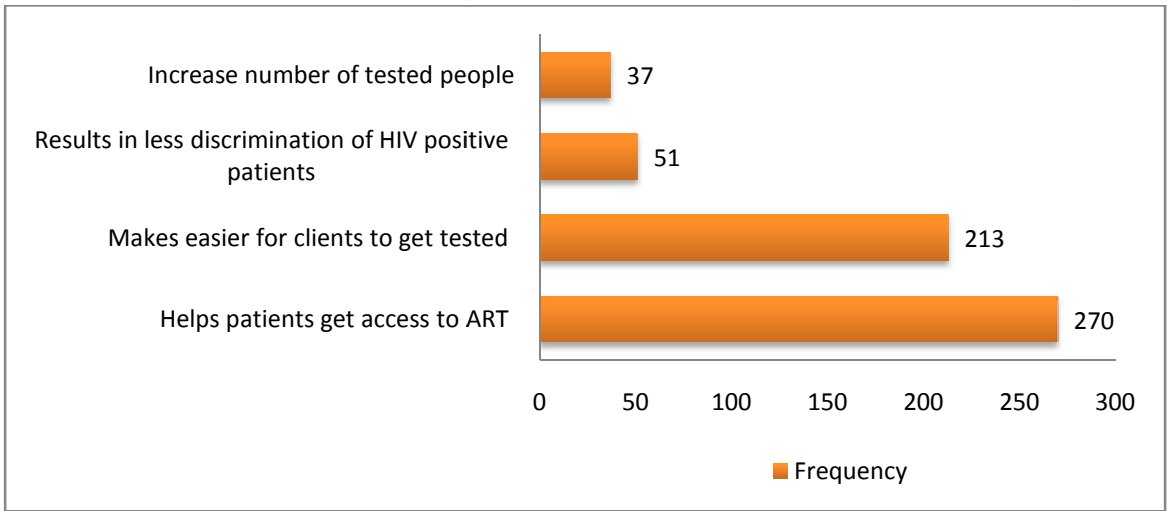

Fig 2: Reasons suggested for saying that PITC is important in DebreBirhan Referral Hospital, 2010.

Three hundred forty five (83.3%) of the participants felt that PITC is important; the reasons given for its importance were that it results in decreased discrimination of HIV-positive patients 51 (14.8%), increase number of tested people 37 (10.7%), makes it easier for clients to get tested 213 (61.7%) and to gain access to ART 270 (78.3%) (Fig 2). On the other hand, 43 (86%) believed that PITC would cause clients to avoid seeing their health providers for fear of being tested, and 10 (20%) thought that routine testing would lead to more violence against women. Out of 345 (83.3%) participants who supported PITC, 204 (57.8%) supported it very much, 126 (35.7%) much and 19 (5.4%) somewhat, while 4 (1.1%) of the study subjects did not support PITC at all (Table 3).

All most all respondents 393 (94.9%) agreed that anyone should check his/her HIV sero-status the timing being at any time 314 (75.8%), before marriage 145 (35.7%), and during illness 94 (22.7%). Two hundred twenty nine (55.3%) of the participants have ever been tested for HIV, the reasons being self interest 172 (41.5%), and 50 (12.1%), 5 (1.2%) and 2 (0.5%) were initiation by health worker, for ANC and blood donation respectively (Table 3).

When asked who needs HIV testing, majority responded that, anyone 362 (87.4%) should be tested for HIV (Table 3 and fig 3).

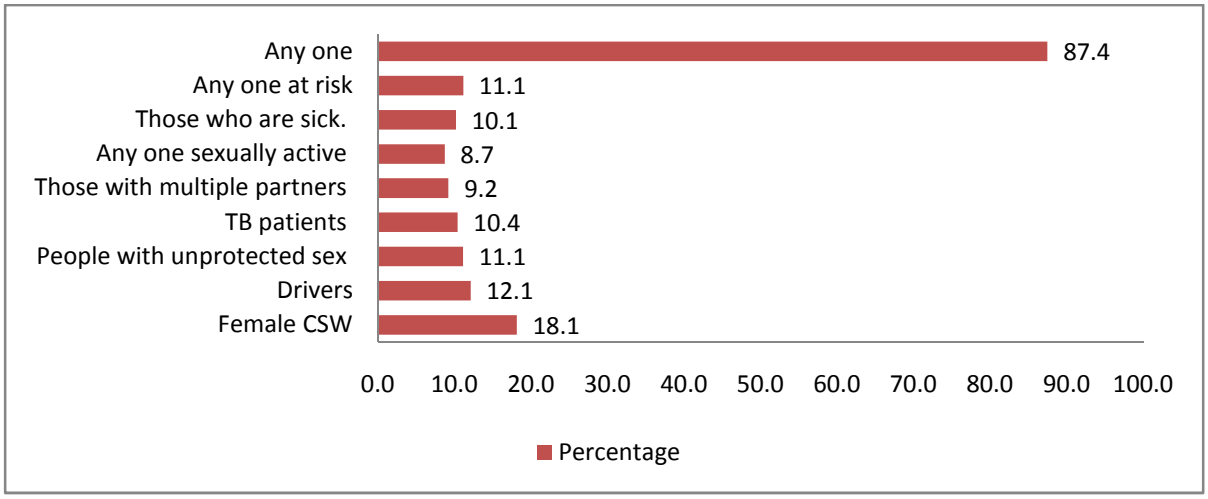

Fig 3: Response of study participants regarding who needs HIV test, DebreBirhan Referral hospital, 2010, (n=414).

Out of the study subjects, 346 (83.6%) accepted PITC (Table 3). The reason for accepting PITC were, heard of TV/radio messages 177 (51.2%), because the health worker recommends it 152 (43.9%), knowing that the treatment is available 67 (19.2%), knowing that the test result will be confidential 56 (16.2%), getting result on the same day 76 (22%) and because he/she is sick 36 (10.4%) (Fig 4).

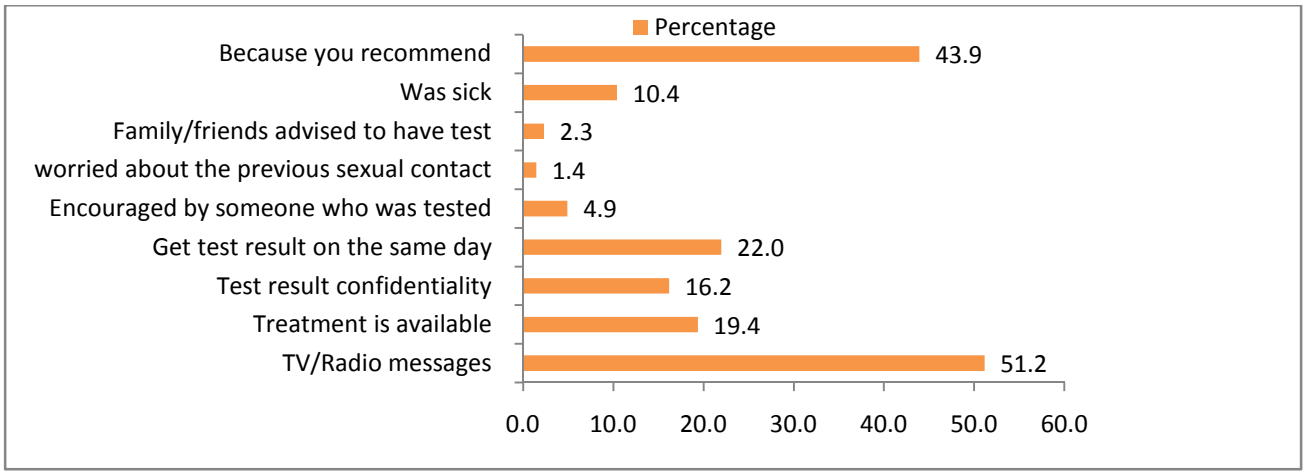

Fig 4: Reasons for accepting PITC among OPD patients, in Debre Birhan Referral Hospital, 2010 (n=346).

Almost one forth agreed that a key reason for not accepting PITC was thinking of not being at risk for HIV, (22.1%) tested before, (19.1%) fear of stigma and discrimination, (8.8%) do not want to know the test result and (5.9%) unable to cope with positive result (Fig 5).

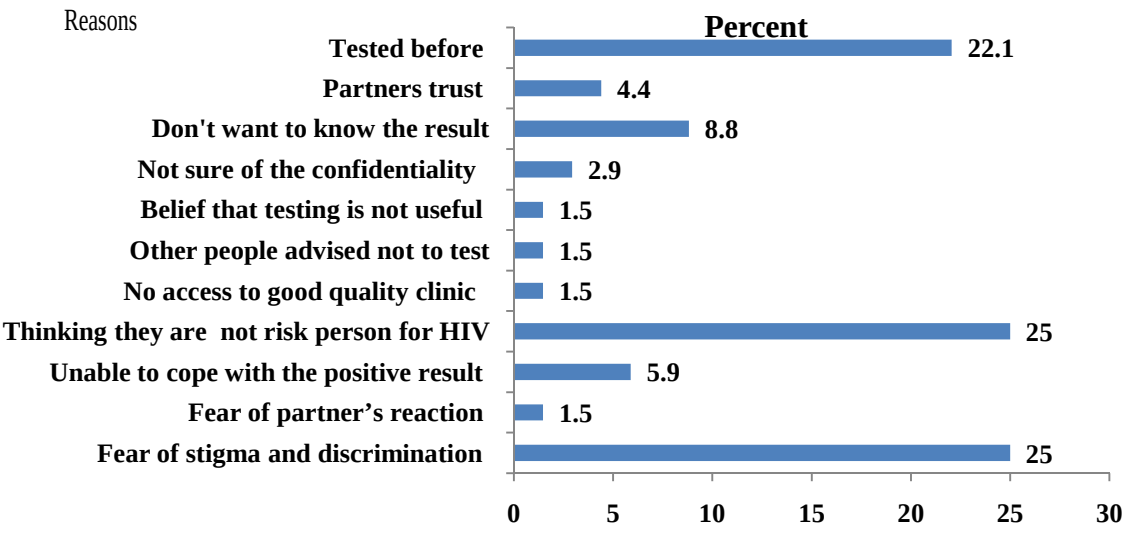

Fig: 5 Reasons for not accepting PITC among OPD patients, in Debre Birhan Referral Hospital, 2010 (n=68).

Of the respondents who accepted PITC, 33 (9.5%) [95% CI (6.4%-12.6%)] were positive for HIV (Table 3).

5.4 Attitude towards test result disclosure

Among the 229 participants who had ever been tested for HIV, 127 were married. One hundred twenty (94.5%) of the respondents disclosed test results to their partners, reaction of being tested was 113 (94.2%) supported and 5 (4.2%) not supported (Table 4). Reasons for non-disclosure among those respondents who did not disclose their test results to their partners (n = 7) were 4 (57.1%) fear of rejection by the partner and 3 (42.9%) conducting test with out permission of partner. Of the 198 respondents, 96 (48.5%) knew that their partners have been tested for HIV and 67 (33.8%) knew that their partners weren't tested for HIV while 29 (14.6%) did not know. Ninety five (99%) of those who knew that their partners been tested for HIV knew about their test results (Table 4)

Table: 4 Attitude towards HIV result disclosure and factors affecting it among OPD patents, DebreBirhan, 2010

Variables	Number	Percentage
Ever tested HIV before (n=414)		
Yes	229	55.3
No	185	44.7
Did you tell your partner about your test result? (n=127)		
Yes	120	94.5
No	7	5.5
Reaction of being tested (n=120)		
Approved/supported	113	94.2
Not supported	5	4.2
Not clear	2	1.6
Reason for no disclosure?(n=7)		
I did it with out his permission	3	42.9
Fear of rejection by the partner	4	57.1
Partner tested previously(n=198)		
Yes	96	48.5
No	67	33.8
I don't know	29	14.6
No response	6	3
Has he/she ever told you about the test result?(n=96)		
Yes	95	99.0
No	1	1.0
Do you have plan to tell your test result to any other person? (n=346)		
Yes	288	83.2
No	58	16.8
How do you see disclosing of your test result to other person?(n=346)		
Easy	211	61.0
Difficult	135	39.0
Would you tell your test result to other person? (n=346)		
Yes	287	82.9
No	59	17.1
Do you think your husband /partner / family would accept HIV test?(n=374)		
Yes	311	83.2
No	24	6.4
I don't know	39	10.4

Of the 346 respondents who accepted PITC, 288 (83.2%) had a plan to tell test results while 58 (16.8%) did not have to tell test result (Table 4). The reason for not telling were fear of stigma 37 (62.7%) followed by fear of blame 8 (13.6%), fear of violence 6 (10.2%), fear of divorce 5 (8.2%) and fear of rejection 3 (5.1%) (Fig 6). About half of the respondents had a plan to tell test results to their husbands or wives (Fig 7).

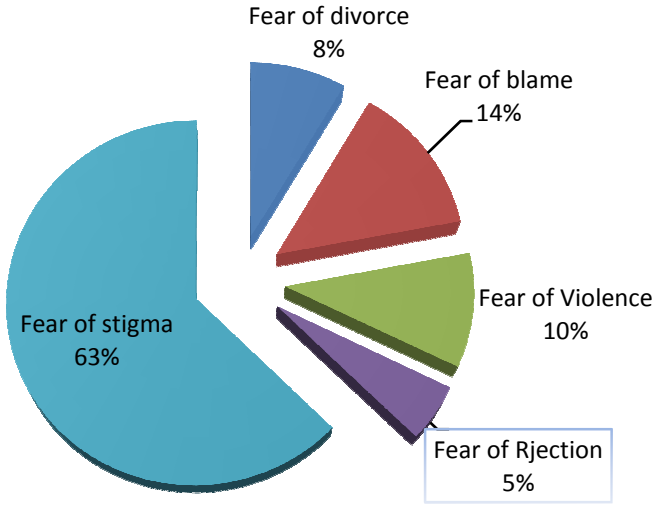

Fig 6: Reason for not disclosing HIV test result, DebreBirhan Referral Hospital, 2010.

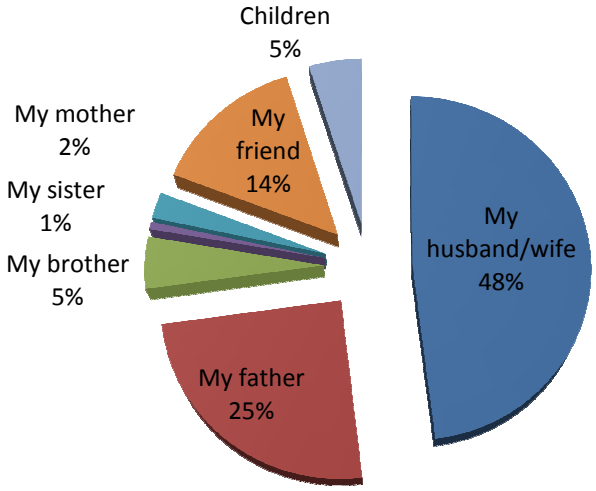

Fig 7: To whom respondents shared their test results, DebreBirhan Referral Hospital, 2010.

5.5 Factors affecting PITC acceptance

The association between different independent variables and PICT acceptance was assessed using binary logistic regression model. Accordingly, age group, ethnicity, marital status and education showed no statistically significant association with PITC acceptance. Similarly, knowing a person infected with (died of) HIV and thinking that they can get the virus showed no association with PITC acceptance. Regarding religion as predictor of PITC acceptance, Protestants were 70% less likely to accept PITC compared to orthodox (COR=0.31, 95% CI=0.1-0.68). PITC acceptance was statistically significant among knowledgeable respondents on HIV transmission than those not knowledgeable about HIV transmission (Table 5).

To determine the independent effect of variables on PITC acceptance, multiple logistic regressions were run. Accordingly, sex (being male) were 2.27 times more likely to accept PITC compared to female (AOR=2.27, 95% CI=1.16-4.42), religion being protestant were 0.21 times less likely to accept PITC compared to orthodox (AOR=0.21, 95% CI=0.06-0.72) and knowledge for HIV transmission was 4.08 times more likely to accept PITC compared with no knowledge for HIV transmission (AOR=4.08, 95% CI=1.98- 9.91) (Table 5).

Table 5: Factors associated with PITC acceptance of OPD patients in DebreBirhan Referral Hospital, 2010

Variable		PITC accepted		COR(95%CI)	Adjusted OR (95%CI)
		Yes	No		
Age (yrs)	15-24	149	32	0.96 (0.46 - 1.99)	0.96 (0.32-2.89)
	25-34	94	14	1.39 (0.6-3.21)	1.49 (0.53-4.17)
	35-44	45	10	0.93 (0.36-2.35)	0.78 (0.27-2.28)
	>=45	58	12	1.0*	1.0*
Sex	Male	194	31	1.51 (0.98-1.01)	**2.27 (1.16-4.42)**
	Female	152	37	1.0*	1.0*
Religion	Orthodox	301	53	1.0*	1.0*
	Muslim	32	7	0.82 (0.34-1.91)	0.71 (0.25-2.02)
	Protestant	12	8	**0.31 (0.1-0.68)**	**0.21 (0.06-0.72)**
Ethnicity	Amhara	311	57	1.0*	1.0*
	Oromo	15	4	0.69 (0.22-2.15)	1.09 (0.28-4.33)
	Gurage	9	2	0.83 (0.17-3.92)	1.11 (0.19-6.62)
	Tigray	6	2	0.55 (0.11-2.79)	0.42 (0.07-2.47)
	Other	5	3	0.31 (0.07-1.31)	0.87 (0.14-5.44)
Marital status	Married	166	28	1.0*	1.0*
	Single	144	33	0.74 (o.43-1.28)	0.5 (0.19-1.26)
	Divorced	17	4	0.72 (0.23-2.29)	1.72 (0.42-7.05)
	Widowed	12	3	0.78 (0.18-2.54)	1.10 (0.23-5.28)
Education	Illiterate	58	11	1.0*	1.0*
	Read and write	61	14	0.83 (0.35-1.970	0.79 (0.28-2.26)
	Primary	64	11	1.11 (0..45-2.74)	1.18 (0.38-3.64)
	Secondary	120	23	0.99 (0.45-2.17)	0.96 (0.27-3.37)
	Tertiary	43	9	0.91 (0.35-2.38)	0.61 (0.14-2.68)
Occupation	Merchant	43	10	1.0*	1.0*
	House wife	54	10	1.25 (0.48-3.29)	1.36 (0.42-4.42)
	Student	124	25	1.15 (0.51-2.6)	1.79 (0.51-6.32)
	Government	52	6	2.02 (0.68-5.99)	2.29 (0.59-8.79)
	NGO employee	16	4	0.93 (0.26-3.39)	1.44 (0.32-6.57)
	Un employed	23	5	1.07 (0.33-3.51)	1.01 (0.25-4.08)
	Daily laborer	7	2	0.81 (0.15-4.56)	0.29 (0.05-1.78)
	Farmer	21	3	1.63 (0.41-6.55)	1.19 (0.25-5.64)
	Other	6	3	0.47 (0.10-2.19)	**4.08 (1.68-9.91)**
HIV transmission knowledge	Knowledgeable	101	8	**3.10 (1.43-6.69)**	**4.08 (1.98-9.91)**
	Not knowledgeable	245	60	1.0*	1.0*
HIV prevention knowledge	Knowledgeable	95	16	1.23 (0.67-2.26)	0.79 (0.38-1.66)
	Not knowledgeable	251	52	1.0*	1.0*
Know a person infected/died of HIV	yes	236	110	0.77 (0.43-1.39)	0.65 (0.33-1.29)
	No	50	18	1.0*	1.0*
Healthy looking person can be positive for HIV	yes	308	63	1.0*	1.0*
	No	38	5	1.56 (0.59-4.11)	1.39 (0.46-4.20)
Do you think you can get the virus?	yes	126	29	1.0*	1.0*
	No	220	39	1.29 (0.77-2.20)	1.48 (0.81-2.71)

5.6 Factors associated with test result disclosure

Crude and adjusted analysis was done to detect any association between test result disclosure and socio-demographic variables, knowledge of HIV transmission, knowledge of HIV prevention and test result (Table 6).

Age group 15-24 was not significantly associated with test result disclosure during the crude analysis; however, it turned to be statistically significantly associated with test result disclosure when adjusted for the other covariates. Those in age group 15-24 were less likely to disclose their HIV status (AOR=0.16, 95% CI=0.04-0.62) (Table 6).

Regarding occupational status, being a student was not significantly associated with test result disclosure compared to merchant, but turned to be significant when adjusted for the other variables compared to merchant (AOR=5.42, 95% CI=1.44-20.43).Daily laborers were 0.13 times less likely to disclose their test result compared to merchants (AOR=0.13, 95% CI=0.02-0.93) (Table 6).

Compared to illiterates those who were able to read and write were less likely to disclose their HIV result (COR=0.28, 95% CI=0.1-0.76), however, it lost its statistical association when adjusted for the other covariates (AOR=0.39, 95% CI=0.12-1.3) (Table 6).

Those with HIV test result negative were 3.32 times more likely to disclose their HIV test result compared to test result positive (COR=3.32, 95% CI=1.53-7.20). When adjusted for confounders, the strength of the association between HIV test result and test result disclosure increased from OR of 3.32 to 4 (AOR=4.00, 95% CI=1.53-10.47) (Table 6).

Table 6: Factors associated with attitudes (willingness) of test result disclosure of OPD patients in DebreBirhan Referral Hospital, 2010

Variable		Willingness		COR(95%CI)	Adjusted OR (95%CI)
		Yes	No		
Age (yrs)	15-24	118	31	0.52 (0.22-1.26)	**0.16 (0.04-0.62)**
	25-34	81	13	0.86 (0.32-2.29)	0.67 (0.19-2.30)
	35-44	38	7	0.75 (0.24-2.30)	0.47 (0.13-1.77)
	>=45	51	7	1.0*	1.0*
Sex	Male	157	37	0.68 (0.38-1.22)	0.71 (0.31-1.61)
	Female	131	21	1.0*	1.0*
Religion	Orthodox	252	49	1.0*	1.0*
	Muslim	25	7	0.69 (0.29-1.69)	0.78 (0.25-2.46)
	Protestant	10	2	0.97 (0.21-4.58)	0.73 (0.12-4.49)
Ethnicity	Amhara	259	52	1.0*	1.0*
	Oromo	11	4	0.55 (0.17-1.80)	0.46 (0.11-1.87)
	Tigray	5	1	1.0 (0.12-8.78)	1.09 (0.10-11.930
	Other	4	1	0.83 (0.88-7.33)	2.36 (0.16-35.81)
Marital status	Married	143	23	1.0*	1.0*
	Single	115	29	0.64 (0.35-1.16)	0.47 (0.17-1.33)
	Divorced	12	5	0.34 (0.12-1.19)	0.32 (0.08-1.35)
	Widowed	11	1	1.77 (0.22-14.36)	0.87 (.08-9.40)
Education	Illiterate	52	6	1.0*	1.0*
	Read and write	43	18	**0.28 (0.10-0.76)**	0.39 (0.12-1.30)
	Primary	56	8	0.81 (0.26-2.49)	1.38 (0.35-5.44)
	Secondary	100	20	0.58 (0.22-1.53)	0.64 (0.16-2.63)
	Tertiary	37	6	0.71 (0.21-2.38)	0.56 (0.11-2.98)
Occupation	Merchant	33	10	1.0*	1.0*
	House wife	47	7	2.04 (0.70-5.89)	1.01 (0.26-4.02)
	Student	105	19	1.68 (0.71-3.96)	**5.42 (1.44-20.43)**
	Government	46	6	2.32 (0.77-7.03)	2.51 (0.63-9.94)
	NGO employee	14	2	2.12 (0.41-10.96)	2.31 (0.34-15.75)
	Un employed	19	4	1.44 (0.39-5.23)	1.28 (0.27-6.04)
	Daily laborer	3	4	0.23 (0.43-1.19)	**0.13 (0.02-0.93)**
	Farmer	16	5	0.97(0.28-3.31)	0.62 (0.14-2.77)
	Other	5	1	1.52 (0.16-14.53)	1.83 (0.14-24.81)
HIV transmission knowledge	Knowledgeable	84	17	.99 (0.53-1.85)	1.26 (0.57-2.80)
	Not knowledgeable	204	41	1.0*	1.0*
HIV prevention knowledge	Knowledgeable	78	17	0.89 (0.49-1.67)	0.78 (0.34-1.76)
	Not knowledgeable	210	41	1.0*	1.0*
HIV test result	Positive	21	12	1.0*	1.0*
	Negative	267	46	**3.32 (1.53-7.20)**	**4.00 (1.53-10.47)**

*-Reference group

6. DISCUSSION

Ethiopia is one of the countries most severely hit by the HIV/AIDS epidemic, with a projected national adult prevalence of 2.4% in 2010 (1, 3). HIV counseling and testing (HCT) is a key strategic entry point to prevention, treatment, care and support services (5). Low uptake of HIV testing is one of the reasons for delayed access to antiretroviral therapy for people in need and in high mortality in the months after treatment is initiated (4, 8).

The use of diverse and appropriate provider-initiated and client-initiated approaches are necessary to expand HIV testing and counselling uptake and facilitate access to prevention, care and treatment services (4). HIV testing and counseling is as well increasingly shifting from the client-initiated model towards other modalities, especially to provider-initiated testing and counselling (4). This study assesses PITC acceptance among OPD clients, test result disclosure and its correlates.

Almost all (99.8%) of our study participants have heard of HIV or the disease designated as AIDS. In line with previous research on knowledge of HIV/AIDS (23) it was found that knowledge about HIV prevention and transmission methods were low which is also comparable with EDHS (15). Only one hundred fifty five (37.4%) of the participants, perceived themselves as having risk for HIV. In this study knowing a person infected/died with HIV and thinking that they can get the virus showed no statistically significant association with PITC acceptance which is consistent with a study done in Addis Ababa (12).

Out of the total interviewed OPD patients, 353 (85.3%) of the participants heard about PITC, their main source of information being health facility 108 (61.0%) followed by mass media 69 (39%). Majority (83.3%) of participants felt that PITC is important. In line with this, 94.5% agreed that anyone should check his/her HIV sero-status and (55.3%) of participants have ever been tested for HIV, which is comparable with another study (12) undertaken earlier.

In this study, PITC acceptance among OPD patients was found to be 83.6%.This was higher than findings done in Addis Ababa 68% (12), 43% in health facilities of Dessie Town (27) and 35% in South Ethiopia (19), but lower than findings of studies in Uganda (98%) (18) and Kenya (97.7%) (21). The

discrepancy could be due to service quality difference, knowledge of ART, knowledge of HIV transmission and study time difference in the respective studies. The reason for accepting PITC were, heard of TV/radio messages 177 (51.2%), because the health worker recommended it 152 (43.9%), knowing that the treatment was available 67 (19.2%), knowing that the test result will be confidential 56 (16.2%), getting result on the same day 76 (22%) and because he/she was sick 36 (10.4%) which is supported by the study conducted in North West Ethiopia (17).

Only 68 (16.4%) of the respondents do not accept PITC. The key reasons for not accepting PITC were (25%) think that they did not consider that they are at risk for HIV, (22.1%) tested before, (19.1%) fear of stigma and discrimination and (8.8%) did not want to know the test result. Such reasons were also mentioned in studies done among TB patients in Addis Ababa (11), OPD patients with clinical sign of HIV infection in Addis Ababa (12), cross-sectional population based studies in Botswana (22) and a case control study in North West Ethiopia (17). Out of the respondents who accepted PITC, 33 (9.5%) were positive for HIV. This is higher than finding of a similar study in Rural Haiti (3.1%) (20), but lower than findings in South Ethiopia (20.6%) (19), Addis Ababa (37.6%) and Kenya (22.7%) (21). This discrepancy could be due to the fact that PITC was provided for patients with sign and symptoms of HIV for the studies in Addis Ababa and South Ethiopia.

This study revealed that PITC acceptance was significantly influenced by sex. Men were 2.27 times more likely to accept PITC than women. The finding in EDHS 2005 also showed that men were more likely to be tested than women (15), but another study showed that there was no statistical association (12). Out of the total respondents who accepted PITC, 85.8% heard of PITC. People who were knowledgeable of HIV transmission were more likely to accept PITC compared to those who did not have knowledge for HIV transmission. The finding was similar with study done in north west Ethiopia (17), but study done in Addis Ababa (12) does not support it. This could be due to operational definition.

Though it was not significant, individuals who read and write were more likely to accept PITC than illiterates and this was in line with a case control study conducted in North West Ethiopia (17). The study finding showed that most common reasons to refuse PITC were that participants felt that they were not at risk for HIV and fear of HIV positive test result. This finding is supported by previously conducted studies in Ethiopia (11, 12).

Majority of the respondents who accepted PITC (83.2%) reflected on a plan to share test result to any other person. Studies conducted in health facilities of Dessie Town, North East Ethiopia and South West Ethiopia on HIV positive clients revealed disclosure rate of 60% and 94.5% respectively (27,28). Researches done in Zambia and Kenya on ANC attending mothers show that the rate of partner disclosure of HIV status amongst study participants ranged from 58 % to 72 % (24).

Only 58 participants (16.6%) who accepted PITC did not have a plan to disclose their results. Consistent with other findings, reasons for no disclosure were fear of stigma 37 (62.7%), followed by fear of blame 8 (13.6%), fear of violence 6 (10.2%) and fear of divorce 5 (8.2%) (25, 26, 28).

Out of 127 married respondents who had ever been tested for HIV, 120 (94.5%) disclosed test results to their partners. Regarding the reaction to those tested, 113 (94.2%) were supported, which was similar to findings reported elsewhere (26, 28). In line with another study in Ethiopia, only seven did not disclose their test results (28). Reasons for non disclosure among those respondents who did not disclose their test results to their partners (n = 7) were 4 (57.1%) fear of rejection by the partner and 3 (42.9%) conducting test with out permission of partner. This was also supported by studies done in ANC attendant mothers in Africa and Ireland (24, 29).

Similar to other findings, respondents reported disclosure most frequently to their husband/wife. Like another study (26), 60% of the respondents felt that disclosing their HIV status was easy. Similar to other findings (24-26), study participants with negative HIV test results were 4 times more likely to disclose their HIV test result compared to those test result positive. Regarding the occupational status, being a student was significantly associated with an intention to disclose test result. Age specific test result disclosure was lower in the age group 15-24.

7. STRENGTHS AND LIMITATIONS OF THE STUDY

Strengths

1. Data collectors were experienced professionals.
2. The study followed the routine procedure in the hospital.
3. Questionnaires were adopted from standard questionnaires of BSS and WHO.

Limitations

1. As the study was conducted in outpatient department attendants, shortage of time is very likely.
2. The study did not use qualitative methods for supplementation of the quantitative assessment.
3. As the data collection was conducted by physicians who treated clients, social desirability bias was likely.
4. As the study was cross sectional there is inevitably difficulty in determining causality.

8. CONCLUSIONS

In general, the findings of this study showed that knowledge about HIV transmission and prevention methods were low. Majority of study subjects agreed that a healthy looking person can be positive for HIV. Majority of the study subjects heard about PITC.

In this study, PITC was highly accepted (83.6%) and we identified multiple factors that influence acceptance of provider initiated HIV testing and counseling. From clients who accepted PITC, the key reason for acceptance were heard of information about PITC from TV/radio messages and the barriers to accept PITC were thought that they were not at risk for HIV.

The prevalence of HIV among the participants was 9.5% which was lower than other study reports. Sex, religion and knowledge of HIV transmission were found to be statistically associated with PITC acceptance.

It is evident from this study, that majority of the participants had positive attitudes towards HIV test result disclosure. The finding of the study showed that nearly one fifth of the study subjects did not want to disclose their HV test result to any one. Fear of stigma, fear of blame and fear of violence were the main reasons that impede HIV test result disclosure. Study subjects with age groups of 15-24, students and test result negatives were more likely to disclose their test result.

9. RECOMMENDATIONS

1. Though PITC acceptance was encouraging, further work should be done not to miss the opportunity.
2. IEC/BCC should target on the change of public perception, about HIV means of transmission, prevention and testing.
3. In the study, PITC acceptance was promising and service provision should be expanded to other health facilities.
4. Prevention, care and support should be strengthened by ZHOs, ZHAPCOs and Referral hospital.
5. IEC/BCC should also target on the change of public perception towards HIV test result disclosure by ZHOs, ZHAPCOs and Referral hospital.
6. Further work should be done on the factors which influenced HIV test result disclosure by ZHOs, ZHAPCOs and Referral hospital.
7. Organizations in the area working on PMTCT program should give emphasis on benefit of test result disclosure.
8. The Zonal Health office, zonal HAPCOs' and Referral Hospital should address stigma and discriminations through strong information, education and communication (IEC)

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ANNEX I: QUESTIONNAIRE (English version)

Participant Information Sheet

Description of the study

Title of the study: Assessment of Provider –Initiated HIV testing and counseling (PITC) acceptance and disclosure and factors related to them, among out patient department (OPD) patients in Debre Birhan Referral Hospital.

Objective of the study: To determine the magnitude of PITC acceptance, disclosure and factors related to them, among OPD patents at DebreBirhan Hospital.

Rationale of the Study and its benefits

HIV/AIDS is a global problem causing the largest burden of morbidity and mortality. In face of currently underway HIV control program, Ethiopia suffers from shortage of data on magnitude of PITC acceptance, disclosure and factors related to it. Therefore, availing scientifically sound data on the aforementioned gaps will have paramount importance for evaluation of the program and different approachs to HIV testing among OPD patients. The envisaged study is designed to assess PITC acceptance, disclosure and factors related to them, while bridging the aforementioned gaps.

Information which is necessary for the study will be collected through interview. You are not subjected to any harm as far as the confidentiality is kept. Moreover, no personal identifiers will be used on data collection form. The recorded data will never be accessed by a third person, except the principal investigator, and will be kept with a firm confidentiality in much secured place and it will not be used for other purposes.

Annex 6: English Consent Form

My name is _____, I am a physician working here in Debre Birhan Referral Hospital and now I am collecting data from our patients coming to OPD for the research being conducted to asses PITC acceptance, Disclosure and factors related to them, among OPD patients, by Ato Awraris Hailu who is the Master of public Health student in the Addis Ababa University. You are selected as one of the study subjects by chance. The investigator employed me for this data collection to maintain your data strictly confidential, i.e not to let others outside of this clinic to access your name and other identifiers. We believe that the findings of this study will have paramount importance for evaluation of HIV programs and to initiate different approaches to HIV testing.

Information which is necessary for the study will be collected by interview. This will not inflict any harm since the confidentiality of information is kept. The information will be taken when you give permission, participation is totally voluntary. It may take 30 minutes.

Your willingness for interview makes information to be utilized in this study and will help us achieve the stated benefits of the study. Your name and other personal identifiers will not be recorded on the data collection form and the information that you give us will be kept confidential and will also be used for the purpose of this study alone. The information that would be taken from you will be quite useful for the study. You will not face any problem if you are not volunteer to give the information. If you have any questions about this study you may ask me or the principal investigator, Awraris Hailu (Tel: 0911373880or E-mail: awrarishailu@yahoo.com)

Are you willing to participate in this study?

1. Yes _____ 2. No _____

Signature of the interviewer which shows that the respondent has consented (verbally) to take part in the study _____

Part One: Socio-Demographic Variables

No	Questions	Classifications	Code	Remark
101	How old were you at your last birthday?	Years (full yrs)		
102	Sex of the client	1.Male 2.Female	1 2	
103	What is your religion?	1.Orthodox 2.Muslim 3.Protestant 4.Catholic 5.Other (specify)____	1 2 3 4 5	
104	To which ethnic group do you belong?	1.Amhara 2.Oromo 3.Gurage 4.Tigray 5.Other (specify)____	1 2 3 4 5	
105	What is your current marital status?	1.Married 2.Single 3.Divorced 4.Widowed 5.Living together	1 2 3 4 5	
106	What is your completed educational status?	1.Illiterate 2.Read and write 3.Primary 4.Secondary 5.Teritary	1 2 3 4 5	
107	What is your current occupation?	1. Merchant 2. House wife 3. Student 4. Government employee 5. NGO employee 6. Un employed 7.Other (Specify)___	1 2 3 4 5 6 7	
108	What is your average household income per month?	1.In cash----- 2.No income 99.No response	1 2 99	

Part Two: -Knowledge about HIV/AIDS

No	Questions	Classifications	Code	Remark
201	Have you ever heard of HIV or the disease called AIDS?	1.Yes 2.No 99.No response	1 2 99	If response is no, stop here
202	Can HIV be cured?	1.Yes 2.No 88.I don't know 99.No response	1 2 88 99	
203	How is HIV/AIDS transmitted? (Multiple response is possible, Needs probing)	1.Sexual intercourse 2.Mother to Child during pregnancy 3.Mother to Child during breastfeeding 4.Transfusion of infected blood 5.Sharing of Sharps with someone who is infected(Needles, etc) 6.shaking hands of a person living with HIV/AIDS 7.wearing clothes of a person living with HIV/AIDS 8.sharing a meal with a person living with HIV/AIDS 9.Mosquito bite 10.Blood contact 11.Other(Specify)____ 99.No response	1 2 3 4 5 6 7 8 9 10 11 99	
204	How can people protect themselves from getting HIV/AIDS? (Multiple response is possible, Needs probing)	1.Avoiding Sex (abstinence) 2.Using a condom every time during sex 3.Staying with only one uninfected faithful partner 4.Others (specify)____ 88.I don't know 99.No response	1 2 3 4 88 99	
205	Do you know any one who is infected with HIV or who has died of AIDS?	1.Yes 2.No 99.No response	1 2 99	
206	Can a healthy looking person be positive for HIV?	1.Yes 2.No 99.No response	1 2 99	

Part three: Personal risk perception

No	Questions	Classifications	Code	Remark
301	Do you think you can get the HIV virus?	1.Yes 2.No 99.No response	1 2 99	If response is no, go to Q 304
302	What are your chances of getting infected with HIV?	1. High 2.Medium 3.Low 99.No response	1 2 3 99	
303	If the answer is moderate or high, what are the reasons?	1. Multiple sexual partner 2. Sexual contact with out Condom 3. Injection with un sterile needle 4.Had sexual contact with HIV positive person 5.Other specify _____ 99.No response	1 2 3 4 5 99	
304	If your response is no to question number 301, what are the reasons	1. I trust my sexual partner. 2.no injection with un sterile needle 3.I always use condom 4.Other specify 99.No response	1 2 3 4 99	

Part four: provider-initiated HIV testing and counseling.

No	Questions	Classifications	Code	Remark
401	Have you ever heard of PIHTC?	1.Yes 2.No 99.No response	1 2 99	If no, go to Q 408
402	If your response to Q401 is yes, where did you get the information? (Multiple response is possible, Needs probing)	1.Health workers 2.Mass media 3.Family member 4.friends 5.Other(specify) 99.No response	1 2 3 4 5 99	
403	To what extent are you in favor of PIHTC?	1. Very much in favor 2. Much 3.Some what 4.Not at all 99.No response	1 2 3 4 99	
404	Do you feel that PIHTC is important?	1.Yes 2.No 88.I don't know 99.No response	1 2 88 99	If no, go to Q 406
405	If your response to Q404 is yes, what are the reasons for feeling that PIHTC is important?	1.Helps patients get access to ART 2.Makes easier for clients to get tested 3.Results in less discrimination of HIV positive patients 4.Increase number of tested people 5.Other(specify)_____ 99.No response	1 2 3 4 5 99	
406	Do you feel that PIHTC has influence on getting services?	1.Yes 2.No 3. I don't know 99.No response	1 2 3 99	If no, go to Q408
407	If your response to Q406 is yes, what are the reasons for feeling that PIHTC has influence?	1.Will cause patients to avoid seeing health professionals for fear of being tested 2.Violet patients human right 3.Leads to more violence against women 4.Other(specify)_____ 99.No response	1 2 3 4 99	
408	Do you agree that any one should check his /her HIV serostatus?	1.Yes 2.No 99.No response	1 2 99	

409	At which time should one be tested for HIV? (Multiple response is possible, Needs probing)	1.When one is sick 2.Before marriage 3.If only has multiple partners 4.At any time 5.Other (specify)_____ 99.No responses	1 2 3 4 5 99	
410	Who are people in need of HIV test? (Multiple response is possible, Needs probing)	1.Female commercial sex workers 2.Drivers 3.People with history of unprotected sex 4.TB patients 5.Those with multiple partners 6. Any one sexually active 7. Those who are sick. 8.Any one at risk 9.Any one 10.Others (specify)_____ 99.No responses	1 2 3 4 5 6 7 8 9 10 99	
411	Have you ever been tested for HIV?	1.Yes 2.No 99.No response	1 2 99	If no, go to Q 414
412	If your response to Q411 is yes, what was the reason for having HIV test?	1.Voluntary testing by your self 2. Initiated by health worker for diagnosis. 3.Donation of blood 4.Ruotine ANC 5.Others(specify)____ 99.No response	1 2 3 4 5 99	
413	If your response to Q 411 is yes, Where did you do your test?	1.Gov hospital/Clinic 2. Gov health center. 3. Stand alone VCT center 4.Private clinic/hospital 5.Others(Specify)____ 99.No response	1 2 3 4 5 99	
414	If your response to Q 411 is no, what are your reasons for not to be tested? (Multiple response is possible, Needs probing)	1.Fear of stigma and discrimination 2.Fear of partner's reaction 3.Unable to cope with the positive result 4. I am not at risk person for HIV 5.Difficult to pay for VCT service 6.Believe that being tested is not useful 7. Not sure of the confidentiality 8.Don't want to know the result 9.Partners trust 10.self trust 11.Other (specify)_____	1 2 3 4 5 6 7 8 9 10 11 99	

		99.No response		
415	The new guideline in Ethiopia for HCT recommends an HIV test for all patents coming to health facilities. So unless you decline we will conduct test for you.	1.Yes 2.No	1 2	If response is no, go 418
416	Record the result of the test.	1.Positive 2.Negative 3.Not known	1 2 3	
417	If your response to Q415 is yes, what were the reasons to be tested?	1.TV/Radio messages 2.Knowing that treatment is available 3.Knowing that test results will be confidential 4.Heard that I could take test and get result on the same day 5.Was encouraged by someone who was tested 6.Was worried about the previous sexual contact 7.Parents/family/friends advised to have test 8.Was sick 9.Because you recommend it 10.other(specify)____ 99.No response	1 2 3 4 5 6 7 8 9 10 99	
418	If your response to Q415 is no, what were your reasons for not being willing to be tested?(Barriers) (Multiple response is possible, Needs probing)	1.Fear of stigma and discrimination following the positive result 2.Fear of partner's reaction 3.Unable to cope with the positive result 4.I am not risk person for HIV 5.Fear of discrimination 6.No access to good quality clinic 7.Other people advised not to test 8.Belief that testing is not useful 9.Not sure of the confidentiality 10.Don't want to know the result 11.Partners trust 12.Tested before 13.Other (specify)____ 88.I don't know 99.No response	1 2 3 4 5 6 7 8 9 10 11 12 13 88 99	

Part five-Attitude towards test result disclosure

No	Questions	Classifications	Code	Remark
501	Have you ever been tested for HIV before?	1.Yes 2.No	1 2	If No ,Q 505
502	If 'yes' did you tell your partner about your test result?	1.Yes 2.No	1 2	If No ,Q504
503	If 'yes' how was his/her reaction with being tested?	1.Approved/supported 2.Not supported 3.Not clear	1 2 3	
504	Why didn't you tell him/her?	1.I did it with out his/her permission 2.Fear of rejection by the partner 3.Other(specify)____	1 2 3	
505	Do you think that partner was tested previously?	1.Yes 2.No 88.I don't know 99.No response	1 2 88 99	If No ,Q 507
506	Has he/she ever told you about the test result?	1.Yes 2.No 99.No response	1 2 99	
507	Do you have plan to tell your test result to any other person?	1.Yes 2.No 99.No response	1 2 99	
508	How do you see disclosing of your test result to other person?	1.Easy 2.Difficult	1 2	
509	Would you tell your test result to another person?	1.Yes 2.No	1 2	If No,Q511
510	To whom do you tell your result?	1.My husband/wife 2.My mother 3.My father 4.My brother 5.My sister 6.My friend 7.My aunt 8.Other….specify	1 2 3 4 5 6 7 8	
511	If no, what are the reasons for not telling the result ?	1.Fear of divorce 2.Fear of blame 3.Fear of Rejection 4.Fear of Violence	1 2 3 4	

		5.Fear of stigma	5	
512	Do you think that your husband /partner / family would accept HIV test?	1.Yes 2.No 88.I don't know 99.No response	1 2 88 99	If no 514
513	What could be some of the reasons you think for acceptance of HIV test?	1.Can start ART 2.appropriate testing place 3.Confidentiality 4.To plan for the future 88.I don't know 99.No response	1 2 3 4 88 99	
514	What could be some of the reasons you think for refusal of HIV testing by your partner or family?	1.Inability to deal with stress of being positive 2.Fear of rejection by the Community 3.Uncertainty on reaction 4.Lack of confidentiality 5.Inappropriate testing place 6.Other (specify)____ 88.I don't know 99.No response	1 2 3 4 5 6 88 99	

ANNEX II: QUESTIONNAIRE (Amharic version)

Annex 5; **Amharic Patient information Sheet**

ለጥናቱ ተሳታፊዎች የሚሰጥ መረጃ

ስለጥናቱ አጭር መግለጫ

የጥናቱ ርዕስ፡- በደብረ ብርሃን ሪፈራል ሆስፒታል በተመላላሽ ህክምና ታካሚዎች ላይ በባለሙያ አነሳሽነት የሚሰጠውን የኤች አይ ቪ ምርመራና የምክር አገልግሎት ተቀባይነት፣ውጤትን ለሌላ መንገርንና የሚወስኑ ሁኔታዎችን መዳሰስ

የጥናቱ ዓላማ፡-በባለሙያ አነሳሽነት የሚሰጡ የኤች አይ ቪ የደም ምርመራና የምክር ተቀባይነትና ውጤትን ለሌላ ሰው የመግለፅ ሁኔታዎችን መለየት

የጥናቱ አስፈላጊነትና ጥቅሙ፡

ኤች አይ ቪ ኤድስ በአለም ደረጃ ከፍተኛ የህመምና የሞት ጫና እያሳደረ ይገኛል አሁን በሚከሄደው የኤች አይ ቪ መከላከል ፕሮግራም በኢትዮጲያ በባለሙያ አነሳሽነት በሚከሄድ የኤች አይ ቪ ምርመራና ምክክር ዙሪያ ያላው መረጃ አነስተኛ ነው፡፡ ስለዚህ ያለውን የመረጃ እጥረት ክፍተት ለማጥበብ በተመላላሽ ታከሚዎች ላይ ስለባለሙያ አነሳሽነት ምርመራና ምክር ምርምር ማድረግ ከፍተኛ ድርሻ አለው፡፡ ይህንኑ ክፍተት ለመሙላት ይህ ጥናት ከፍተኛ ጥቅም አለው፡፡ ለጥናቱ የሚያስፈልገው መረጃ በጥያቄ መልኩ ይሰበሰባል፡፡ የመረጃዉ ሚስጥራዊነት እስከተጠበቀ ድረስ እርሶን የሚጎዳ ምንም ነገር የለም፡፡ ስሞትንና ማንነቶን የሚገልፅ ማንኛውም መለያ በጥናቱ አይከተቱም፡፡ ይህ የተመዘገበው መረጃ ለሌላ ሶስተኛ አከል ከዋናው ተመራማሪ ውጪ አይተላለፍም በሚስጥራዊነት ይቀመጣል እንዲሁም መረጃው ለሌላ ጥቅም አይውልም፡፡

ስለጥናቱ መረጃና መጠይቅ

01.የመጠይቁ መለያ ቁጥር----------(000)

መግቢያ፤ስሜ ----------ይባላል፡፡ እኔ በዚሁ ሆስፒታል የምሰራ ጤና ባለሙያ ስሆን በዚሁ ጤና ድርጅት ለተለያዩ ተመላላሽ ህክምና የሚመጡትን ግለሰቦች በባለሙያዎች አነሳሽነት በሚደረግ የኤች አይ ቪ የምክርና የደም ምርመራ ተቀባይነትና ፤ዉጤትን ለሌላ ሰዉ መግለጽን የሚወስኑ ሁኔታዎች በተመለከተ በአዲስ አበባ ዩኒቨርስቲ ድህረ ምለቃ ተማሪ በሆነዉ በአቶ አዉራሪስ ሀይሉ ምርምር በመድረግ ላይ ይገኛል፡፡ እርሶም የጥናቱ አካል እንዲሆኑ ተመርጠዋል፡፡ በሀገራችን ፕሮግራሙ ከተጀመረ በኋላ በጉዳዩ ዙሪያ የተደረጉ ጥናቶች ብዙም ባለመኖራቸዉ የእርሶ ምላሽ በባለሙያዎች አነሳሽነት የሚደረግ የኤች አይ ቪ የደም ምርመራን ተቀባይነት በተመለከተ ግንዛቤን በመጨመር የሚመለከታቸዉ አገልግሎት ሰጪዎች ፖሊሲያቸዉን በመቀየር የበለጠ በብዙ ሰዎች ዘንድ ተቀባይነት እንዲያገኝ ለማድረግ ይረዳል፡፡ ቃለ መጠይቁ 20-30 ደቂቃ ልፈጅ ይችላል፡፡ የመረጃዉ ሚስጢራዊነት በደንብ ይጠበቃል፡፡ የጥናቱ ዉጤት ቢታተም እንኳን የጥናቱ ተሳታፊዎች ማጠቃለያ ሀሳብ በቻ ነዉ የሚጠቆመዉ፡፡ ማንኛዉንም ግልጽ ያልሆነ ነገር ካለ መወያየት እንችላለን፡፡ በጥናቱ ያለመሳተፍ በማንኛዉም መልኩ ማንኛዉንም አገልግሎት ከማግኘት አያግድም፡፡ ቃለ ምልልሱ ፍጹም ሚስጢራዊና ለማንኛዉም አካል ተላልፎ የማይሰጥ ሲሆን ምላሾትን የምንጠቀመዉ ለዚህ ጥናት ብቻ ነዉ፡፡ ስምዎትንና ማንነትዎን የሚገልጽ ማንኛዉንም መለያ በማጠቃለያ ሂደት ዉስጥ አይካተትም፡፡ምላሽዎ የሚወከለዉ መረጃ ሰብሳቢ በሚሰጠዉ መለያ ቁጥር ብቻ ነዉ፡፡ በጥናቱ ዙርያ ጥያቄ ካለዎት ከእኔ ጋር ወይም ዋናዉን አጥኚ አዉራሪስ ሀይሉን በስልክ ቁጥር 0911373880 በኢ-ሜል፡ awrarishailu@yahoo.com ማነጋገር ይችላሉ፡፡

በጥናቱ ለመሳትፍ ፈቃደኛ ነዎት? 1.አዎ 2.አይደለሁም አመሰግናለሁ!!

ለመሳተፍ ፈቃደኛ የሆኑ እንደሆን ወደሚቀጥለዉ ገጽ እለፍ

መጠይቁን የሞላዉ ሰዉ ፊርማ የሚያሳየዉ በጥናቱ ለመሳተፍ የፈቃደኝነት ቃል መቀበሉን ነዉ፡፡

ስም----------ፊርማ----------ቀን-------ወር----------2003 ዓ.ም

ያረጋገጠዉ ሱፐርቫይዘር ስም----------ፊርማ----------ቀን----------

ክፍል አንድ፡ ስለማህበራዊ ሁኔታ የሚያመለክቱ ጥያቄዎች

ተ.ቁ	ጥያቄዎች	መልስ ሊሆኑ የሚችሉዝርዝሮች	አስተያየት
101	እድሜዎ ስንት ነው?	----------ዓመት/በሙሉ ዓመት ይገለፅ	
102	የተጠያቂው ፆታ	1 ወንድ 2 ሴት	
103	ሐይማኖትዎ ምንድን ነው?	1 ኦርቶዶክስ 2 ሙስሊም 3 ፕሮቴስታንት 4 ካቶሊክ 5 ሌላ ካለ ይገለፅ 99 መልስ የለም	
104	ብሔር ምንድን ነው?	1 አማራ 2 ኦሮሞ 3 ጉራጌ 4 ትግራይ 5 ሌላ ካለ ይገለፅ---------- 99 መልስ የለም	
105	በአሁኑ ወቅት የጋብቻ ሁኔታዎ እንዴትነው?	1 ያገቡ 2 ያላገቡ 3 የተፋቱ 4 ባል/ሚስት የሞተባቸው 5 ያልተጋቡ ጥንዶች	
106	ተምረው የጨረሱት ከፍተኛው የትምህርት ደረጃ ስንት ነው?	*1 ያልተማረ* 2 *ማንበብና መፃፍ የሚችል* *3 አንደኛ ደረጃ ያጠናቀቀ* *4 ሁለተኛ ደረጃ ያጠናቀቀ* *5 ከፍተኛ ደረጃ ያጠናቀቀ*	
107	በአሁኑ ወቅት ያሉበት የስራ አይነት ምንድን ነው?	1 ነጋዴ 2 የቤት እመቤት 3 ተማሪ 4 የመንግስት ሰራተኛ 5 *መንግስታዊ ያልሆነ ድርጅት ሠራተኛ* 6 ስራ የሌለው 7 ሌላ ካለ ይገለፅ----------	
108	ጠቅላላ የቤተሰብ አማካይ የወር ገቢ ስንትነው?	1 የኢ/ብር---------- 2 ገቢ የሌለው 99 መልስ የለም	

ክፍል ሁለት፡ ስለ ኤች.አይ.ቪ ኤድስ ያለዎትን እውቀት አስተያየት

ተ.ቁ	ጥያቄዎች	መልስ ሊሆኑ የሚችሉ ዝርዝሮች	አስተያየት
201	ስለ ኤች አይ ቪ/ኤድስ በሽታ ሰምተው ያውቃሉ?	1 አዎ ሰምቻለሁ 2 አልሰማሁም 99 መልስ የለም	መልስዎ አልሰማሁም ከሆነ ቃለመጠይቁን እዚህ ላይ ይጨርሱ
202	የኤች አይ ቪ ኤድስ በሽታ ፈዋሽ መድኃኒት ያለው ይመስልዎታል?	1 አዎ 2 የለውም 88 አላውቅም 99 መልስ የለም	
203	የኤች አይ ቪ ኤድስ በሽታ በምንመንገድ ሊተላለፍ ይችላል? -ከአንድ በላይ መልስ ይቻላል። አታንብበው የሚሰጡትን መልስ ?	1 በግብረ ሥጋ ግንኙነት 2 ከእናት ወደ ፅንስ በእርግዝና ጊዜ 3 ከእናት ወደ ልጅ በጡት መጥባት 4 በኤች አይቪኤድስ የተበከለ ደም መቀበል 5 ኤች አይ ቪ ኤድስ ከያዘው ሰው ጋርበጋራ ስለታም ነገሮችን መጠቀም 6 መጨባበጥ 7 የኤች አይ ቪ ኤድስ በሽታኛ ልብሶች መልበስ 8 ኤች አይ ቪኤድስ ከያዘው ሰው ጋርአብሮ መመገብ 9 በወባ ትንኝ 10 በደም ንክኪ 11 ሌላ ካለ ይገለፅ ---------- 99 መልስ የለም	
204	አንድ ሰው በኤች አይ ቪ ኤድስ እንዳይያዝ በምን መንገድ መከላከል ይቻላል? -ከአንድ በላይ መልስ ይቻላል። አታንብበው የሚሰጡትን መልስ ?	1 ከግብረ ስጋ ግንኙነት በመቆጠብ 2 ግብረ ስጋግንኙነት በፈፀሙ ቁጥር ኮንዶም መጠቀም 3 ከበሽታ ነፃ ከሆነ/ች ጋር አንድ ለአንድመወሰን 4 ሌላ ካለ ይጠቀስ---------- 88 አላውቅም 99 መልስ የለም	
205	ከኤች አይ ቪ ጋር የሚኖር አልያም በኤድስ በሽታ የታመመ ወይም በበሽታው የሞተ ሰው ያውቃሉ?	1 አውቃለሁ 2 አላውቅም 99መልስ የለም	
206	ጤነኛ የሚመስሉ ሰዎች የኤች አይ ቪቫይረስ ሊኖርባቸው ይችላል?	1 ይችላል 2 አይችልም 99 መልስ የለም	

ክፍል ሦስት፡ ስለ ኤች አይ ቪ ኤድስ የመጋለጥ ግላዊ እሳቤ

ተ.ቁ	ጥያቄዎች	መልስ ሊሆኑ የሚችሉዝርዝሮች	አስተያየት
301	የኤች አይ ቪ ቫይረስ ሊይዘኝ ይችላል ብለው ያስባሉን?	1 አዎ 2 አላስብም 99 መልስ የለም	መልሱ አላስብም ከሆነ ወደቁጥር304 ይሂዱ
302	የራስዎ የኤች አይ ቪ/ኤድስ ተጋለጭነት ምን ያህል ይመስልዎታል?	1 በጣም ተጋላጭ ነኝ 2 መካከለኛ ተጋላጭ ነኝ 3 አነስተኛ ተጋላጭ ነኝ 99መልስ የለም	መልሱ አነስተኛ ተጋላጭ ነኝ ከሆነወደ ቁጥር 401ይሂዱ
303	የጥያቄ 302 መልስ መካከለኛና በጣም ተጋላጭ ከሆነ ምክኒያቱ ምንድነው? -ከአንድ በላይ መልስ ይቻላል?	1 ብዙ የወሲብ ጓደኞች ስለነበሩኝ 2 ያለ ኮንዶም የግብረ ስጋ ግንኙነት ስለፈፀምኩ 3 ሌላ ሰው በተጠቀመበት መርፌ ስለተጠቀምኩ 4 ኤች አይ ቪ ፖዘቲቭ ከሆነ ሰው ጋር የግብረ ስጋግንኙነት ስለፈፀምኩ 5 ሌላ ካለ ይጠቀስ 99 መልስ የለም	
304	የጥያቄ 301 መልስ አላስብም ከሆነምክኒያቱ ምንድን ነው?	1 በአንድ ሰው ተወስኜ ስለምኖር 2 በተበከለ መርፌ ስለማልጠቀም 3 ሁልጊዜ ኮንደም ስለምጠቀም 5 ሌላ ካለ ይጠቀስ ---------- 99 መልስ የለም	

ክፍል አራት ፡ በጤና ባለሙያ አነሳሽነት ላይ የተመሰረተ የኤች አይ ቪ ምርመራና ምክር አገልግሎት አጠቃቀም

ተ.ቀ	ጥያቄዎች	መልስ ሊሆኑ የሚችሉዝርዝሮች	አስተያየት
401	በጤና ባለሙያ አነሳሽነት ላይ የተመሠረተየኤች አይ ቪ ኤድስ ምክርና ምርመራ አገልግሎት መኖሩን ሰምተው ያውቃሉ?	1 ሰምቻለሁ 2 አልሰማሁም 99 መልስ የለም	መልሱ አልሰማሁም ከሆነ ወደ ቁጥር 408ይሂዱ
402	ለቁጥር 401 መልሱ ሰምቻለሁ ከሆነ መረጃውን ከየት ነው ያገኙት?	1 ከጤና ባለሙያዎች/ተቋማት 2 ብዙሀን መገናኛ 3 ከቤተሰብ 4 ከጓደኛ 5 ሌላ ካለ ይጠቀስ ---------- 99 መልስ የለም	
403	በጤና ባለሙያ አነሳሽነት ላይ የተመሰረተየኤች አይ ኤድስ ምርመራ አገልግሎትን ምን ያህል ይደግፋሉ?	1 እጅግ በጣም 2 በጣም 3 በመጠኑ 4 አልደግፍም 99 መልስ የለም	
404	በጤና ባለሙያ አነሳሽነት ላይ የተመሰረተ የኤች አይ ቪ ምክርና ምርመራ አገልግሎት ጠቃሚ ነው ብለው ያስባሉ?	1 አዎ 2 አይጠቅምም 88 አላውቀውም 99 መልስ የለም	መልሱ አይጠቅምም ከሆነ ወደ406 ይሂዱ
405	በቁጥር 404 መልሱ አዎ ከሆነ በጤና ባለሙያ አነሳሽነት ላይ የተመሰረተ የኤች አይቪ ምክርና ምርመራ ለህሙማን መጀመሩ ምን ጥቅም አለው ብለው ያስባሉ? -ከአንድ በላይ መልስ ይቻላል?	1 ህሙማን የፀረ ኤድስ መድሃኒት እንዲያገኙ ይረዳል 2 ህሙማን በቀላሉ እንዲመረመሩ ያደርጋል 3 ኤች አይ ቪ ፖዘቲቭ በሆኑ ህሙማን ላይ የሚደረግ አድልዎን ይቀንሳል 4 የተመርማሪ ቁጥር እንዲጨምር ያደርጋል 5 ሌላ ካለ ይገለጽ---------- 99 መልስ የለም	
406	በጤና ባለሙያ አነሳሽነት ላይ የተመሰረተ የአች አይ ቪ ምክርና ምርመራ አገልግሎት ተፅዕኖ አለው ብለው ያስባሉ?	1 አዎ 2 የለውም 88 አላውቀውም 99 መልስ የለም	መልሱ የለውም ከሆነ ወደ 408ይሂዱ
407	በቁጥር 406 መልሰ አዎ ከሆነ በጤና ባለሙያ አነሳሽነት ላይ የተመሰረተ የኤች አይ ቪ ምርመራና ምክር አገልግሎት መጀመር ምን ተፅዕኖ ይኖረዋል ብለው ያስባሉ? -ከአንድ በላይ መልስ ይቻላል?	1 ህሙማን የኤች አይ ቪ ምርመራን በመፍራት ወደ ህክምና ማዕከል እንዳይሄዱያደርጋል 2 የህሙማን ሰብአዊ መብት ሊጥስ ይችላል 3 በሴቶች ላይ ያታዊ ጥቃት እንዲደርስ ያደርጋል 4 ሌላ ካለ ይጠቀስ ---------- 99 መልስ የለም	

408	ማንኛውም ሰው የኤች አይ ቪ ምርመና ማድረግ አለበት ብለው ይስማማሉ?	1 አዎ 2 አልስማማም 99 መልስ የለም	
409	አንድ ሰው የኤች አይ ቪ ምርመራ ማድረግ ያለበት መቼ ነው? ከአንድ በላይ መልስ ይቻላል?	1 ሲታመም 2 ከጋብቻ በፊት 3 ከአንድ በላይ ወሲብ ጓደኛ ሲኖረው 4 በማንኛውም ጊዜ 5 ሌላ ካለ ይጠቀስ ---------- 99 መልስ የለም	
410	የኤች አይ ቪ ምርመራ የሚያስፈልገው ለማን ነው ይላሉ?-ከአንድ በላይ መልስ ይቻላል:: አታንብበው የሚሰጡትን መልስ ?	1 ሴተኛ አዳሪዎች 2 ሾፌሮች 3 ያለ ኮንዶም የግብረ ስጋ ግንኙነትያደረገ/ች 4 ለቲቢ ህመሙማን 5 ከአንድ በላይ ወሲብ ጓደኛ ያለው 6 የግብረ-ስጋ ግንኙነት ማድረግ የጀመረ/ች 7 ለታመሙ ሰዎች 8 ማንኛውም ኤች አይ ቪ ተጋላጭ ለሆነ ሰው 9 ለማንኛውም ሰው 10 ሌላ ካለ ይጠቀስ---------- 99 መልስ የለም	
411	የኤች አይ ቪ ምርመራ አድርገው ያውቃሉ?	1 ተመርምሬ አውቃለሁ 2 ተመርምሬ አላውቅም	መልስዎ ተመርምሬ አላውቅም ከሆነ ወደ ቁጥር 414 ይይሂዱ
412	ለቁጥር 411 መልስዎ አዎ ከሆነ በምን ምክንያት ነበር የኤች አይ ቪ ምርመራ ያደረጉት?	1 በራሴ ፍላጎትና ጥያቄ 2 በጤና ባለሙያ ትዕዛዝ 3 የደም ልገሣ ለማድረግ 4 በእርግዝና ክትትሌ ጊዜ 5 ሌላ ካለ ይጠቀስ---------- 99 መልስ የለም	
413	ለቁጥር 411ኛው ጥያቄ መልሱ አዎ ከሆነ የኢች አይ ቪ ምርመራ ያደረጉት የትነው?	1 የመንግስት ሆስፒታል/ክሊኒክ 2 የመንግስት ጤና ጣቢያ 3 ለኤች አይ ቪምርመራ አገልግሎት ብቻ የሚሰጡ ድርጅቶች 4 የግል ሆስፒታል/ክሊኒክ 5 ሌላ ካለ ይጠቀስ---------- 99 መልስ የለም	
414	ለቁጥር 411 መልስዎ ተመርምሬ አላውቅም ከሆነ በምን ምክንያት ነው የ ኤች አይ ቪ ምርመራ ያላደረጉት?-ከአንድ በላይ መልስ አታንብበው የሚሰጡትን ሁሉ መልስ።	1 አድልዎና መገለል በመፍራት 2 የጓደኛ ቁጣ መፍራት 3 ውጤት ለመቀበል ስለምፈራ 4 ኤች አይ ቪ ይይዘኛል ብዬስለማላስብ 5 የኤች አይ ቪ ምርመራ ዋጋ መክፈል ስለማልችል 6 መመርመር ጥቅም አለው ብዬስለማላምን 7 ሚስጢራዊነቱን መጠበቁን ስለምጠራር 8 ውጤቱን ማወቅ ስለማልፈልግ	

		9 ጓደኛዬን ስለማምነው 10 ራሴን ስለማምነው 11 ሌላ ካለ ይጠቀስ---------- 99 መልስ የለም	
415	የኢትዮጵያ አዲሱ የኤች አይ ቪ ምርመራ ምክር አገልግሎት አሰራር እንደሚያትተው፣ ማንኛውም ሰው አገልግሎቱን እንዲያገኙ ያደርጋል።ስለዚህ እርሶ እስካልተቃወሙኝ ድረስ ምርመራዉን አደርግሎታለሁ።።	1 አዎ ፈቃደኛ ነኝ 2 አይ ፈቃደኛ አይደለሁም	መልሱ ፈቃደኛ አይደለሁም ከሆነ ወደ ቁጥር417 ይሂድ
416	የምርመራውን ውጤት ይመዝገቡ	1 ፖዘቲቭ 2 ኔጌቲቭ 88 አላውቅም	
417	ለጥያቄ 415 መልሱ አዎ ከሆነ አገልግሎቱን ለመቀበል ምን አነሳሳህ/ሽ? -ከአንድ በላይ መልስ ይቻላል?	1 በሬዲዮ/ቲቪ የሚነገሩ መልዕክቶች 2 መድኃኒቱ መኖሩን ማወቄ 3 ውጤቱ በሚስጥር እንደሚያዝ በማወቄ 4 በአንድ ቀን ውስጥ ተመርምሮ ውጤት ማወቅ ስለሚቻል 5 ከዚህ በፊት ተመርምሮ በሚያውቅ ሰው ተገፋፍቼ 6 በፊት ስለነበረኝ የግብረስጋ ግንኙነት በመጨነቅ 7 ቤተሰቦቼና ጓደኞቼ ስለመከሩኝ 8 ስለታመምኩ 9 እርሶ ስላዘዙኝ 10 ሌላ ካለ ይጠቀስ---------- 99 መልሱ አልተሰጠም	
418	ለጥያቄ 415 መልሱ አይ ከሆነ አገልግሎቱን ላለመቀበል ምክንያቶች/እንቅፋቶችን ይጠቀሱ? -ከአንድ በላይ መልስ ይቻላል?	1 አድልዎና መገለል በመፍራት *2 በባለሙያ አድልዎና/መገለልዕ/ በመፍራት* 3 የጓደኛ ቁጣ መፍራት 4 ውጤት ለመቀበል ስለምፈራ 5 ኤች አይ ቪ ይይዘኛል ብዬ ስለማላስብ *6 ጥሩ እና ጥራት ያለው የህክምና ማዕከል አቅርቦት ስለሌለ* *7 ሌሎች ሰዎች እንዳልመረመር ስለመከሩኝ* *8 መመርመር ጥቅም አለው ብዬስለማላምን* 9 ሚስጢራዊነቱንመጠበቁን ስለራጠር 10 ውጤቱን ማወቅ ስለማልፈልግ 11 ጓደኛዬን ስለማምነው *12 ተመርምሬ ስለማውቅ* 13 ሌላ ካለ ይጠቀስ---------- 99 መልስ የለም	

ክፍል አምስት፡ የኤች.አይ.ቪ ኤድስ የምርመራ ዉጤትን ስለመንገር ያለዎትን እውቀት አስተያየት

ተ.ቀ	ጥያቄዎች	መልስ ሊሆኑ የሚችሉዝርዝሮች	አስተያየት
501	ለኤች አይቪ ኤድስ ምርመራ አድርገው ያውቃሉ?	1 አዎ አድርጊያለሁ 2 አይ አድርጌ አላኩምቅም	መልሱ አላደረከም ከሆነ ወደ ተቁ 505 ይሂዱ
502	መልሱ አድርጊያለሁ ከሆነ ለተጓዳኛዎ የምርመራ ውጤቱን ነግረዋል?	1 አዎ ነግሪያለሁ 2 አልነገርኩም	መልሱ አልነገርኩም ከሆነ ወደ ተቁ 504 ይሂዱ
503	መልስዎ ነግሬአለሁ ከሆነ ስለርስዎ መመርመር የተጓዳኝዎ ስሜት ምንድን ነበር?	1 ደግፎኛል 2 ተቃውሚል 3 ግልፅ አልነበረም	
504	ለምን ነበር ያልነገርሽዉ/ከዉ?	1 የተመረመርኩት ያለእርሱ ፍቃድ ነበር 2 እጣላለሁ ብዬ ስለፈራሁ 3 ሌላ ካለ ይጥቀሱ----------	
505	ተጓዳኝዎ ከዚህ በፊት ተመርምረዋል ብለው ያስባሉ?	1 እዎ ተመርምረዋል 2 አይ አልተመረመሩም 88 አላውቅም 99 መልሰስ የለም	መልሱ አልተመረመሩም ከሆነ ከሆነ ወደ ተቁ 507 ይሂዱ
506	ስለ ውጤቱ ነግሮታል?	1 አዎ ነግሮኛል 2 አይ አልነገረኝም 99 መልስ የለም	
507	የምርመራ ውጤቶን ለሌላ የመንገር እቅድ አልዎት?	1 አዎ አቅዳለሁ 2 አይ አላቀድኩም 99 መልስ የለም	
508	የምርመራ ውጤቶን ለሌላ ሰው መንገርን እንዴት ያዩታል?	1 ቀላል ነው 2 ያስቸግራል	
509	የምርመራ ውጤቶን ለሌላ ሰው ይነግራሉ?	1 አዎ እነግራለሁ 2 አይ አልነግርም	መልስዎ አልናገርም ከሆነ ወደ 511 ይሂዱ
510	ለማን ነው ውጤቶን የሚነግሩት?	1 ለሚስት/ለባል 2 ለእናቴ 3 ለአባቴ 4 ለወንድሜ 5 ለእህቴ 6 ለጓደኛዬ 7 ለአክስቴ 8 ሌላ ካለ ይጠቀስ----------	

511	መልስዎ አልነግርም ከሆነ ውጤቶን ላለመንገር ምክንያቶ ምንድን ነው?	1 ትዳሬ እንዳይፈርስ በመፍራት 2 መወቃቀስ በመፍራት 3 መጠላትን በመፍራ 4 ፀብን በመፍራ 5 መገለልን በመፍራት	
512	የእርሶ ቤተሰብ የኤች አይ ቪ ምርመራን ይቀበሉኛል ብለው ያስባሉ?	1 አዎ ይቀበላሉ 2 አይ አይቀበሉም 88 አላውቅም 99 መልስ የለም	መልሱ አይቀበሉም ከሆነ ወደ 514 ይሂዱ
513	የኤች አይ ቪ የሚቀበሉበት ምንያቶች ጥቂቶቹ እነማን ናቸው?	1 ፀረ ኤች አይ ቪ መድሃኒት ለመጀመር 2 የመመርመሪያው ቦታው ጥሩ ስለሆነ 3 ሚስጥራዊነቱ ስለሚጠበቅ 4 ለወደፊት ለማቀድ 88 አላውቅም 99 መልስ የለም	
514	ምርመራ ላለመቀበላቸው ምክንያቶቹ ምን ምን ናቸው?	1 ፖዝቲፍ ውጤትን መቀበል ስለሚያስፈራ 2 በህብረተሰቡ ዘንድ መገለልን በመፍራት 3 ስለ ስሜታቸው እርግጠኛ ስለማይሆኑ 4 ሚስጥራዊነት አለመጠበቅ 5 ጥሩ ያልሆነ የምርመራ ቦታ ስለሆነ 6 ሌላ ካለ ይጠቀስ---------- 88 አላውቅም 99 መላስ የለም	

ANNEX III: KNOWLEDGE ASSESSING QUSTIONS

Questions used to assess knowledge about HIV transmission

1. If HIV is transmitted through sexual intercourse
2. If HIV is transmitted from mother to child during pregnancy
3. If HIV is transmitted from mother to child during breast feeding
4. If HIV is transmitted through blood contact
5. If HIV is transmitted by sharing of sharp materials with someone who is infected.

Participants will be scored as knowledgeable if the mean score of the response on HIV transmission questions is above the mean while they were considered as not knowledgeable if the mean score is less than or equal to the mean score of the response.

Questions used to assess misconceptions about HIV/AIDS

1. If HIV is transmitted by shaking hands of a person living with HIV
2. If HIV is transmitted by wearing of cloths of a person living with HIV
3. If HIV is transmitted by sharing meal with a person living with HIV
4. If HIV is transmitted through mosquito bite.

Study participants were considered to have misconceptions about HIV/ AIDS transmission and prevention if, they agreed incorrectly to any of the four misconception questions

Questions used to assess knowledge on means of HIV prevention

1. If HIV is prevented by abstinence
2. If HIV is prevented by staying faithful with one uninfected partner
3. If HIV is prevented by using condom every time during sex

Respondents were considered to be knowledgeable about HIV prevention if the mean score of the response on HIV prevention questions is above the mean while they were considered as not knowledgeable if the mean score is less than or equal to the mean score of the response.

ANNEX IV: DECLARATION

I the undersigned, declare that this thesis is my original work conducted in partial fulfillment of the requirement for the Degree of Master of Public Health and has not been presented for a degree in this or any other university. All sources of materials used for this thesis have been duly acknowledged.

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Date of submission_____

This thesis has been submitted for examination with my approval as the University advisors

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Date: _____